State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 **Physician** April 2008 6:54 p^M F. STURGEON **JAMES** SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7758 Lyman Avenue Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 02,1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 M M 2 ☐ F Months Days Hours **Director** 216-24-4562 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 ☐ Yes 2 🗷 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 7758 Lyman Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify þ Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Rug Company 0wner 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Powe11 Lillian Sturgeon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1436 Decatur Street, Baltimore, Maryland 21230 Ronald Glacken (grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 04-23-08 Loudon Park Cem. 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a Part 1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death dying, such as pardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) hoscherotic **Physician** /Medical Due to (or as a consequence of): Examiner Gutern cromarin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check onl one) examiner? Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending deaih. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 1041 O Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 370 31. Date filed (Month, Day, Year)
APR 2 10untain

32. Resistrar's Signature

2 2008

Baltimore, Maryland 21215-0036 MALLWOOD

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Records, P.O. Box 68760,	The law requires that the death conficate be executed
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ivision or Vital Re	
Divisio	tal or Attending Physician

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL пау 2008 **Physician** Elizabeth Smallwood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIEN BURNIE BALTIMORE WARHINGTON MEDICAL CENTER AUNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 212-28-2871 May 22,1920 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Tyes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7852 Dero Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ð 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 N/A Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Marcellus С. F1ood Gracie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene A. Smallwood (Son) 1339 Hallock Drive Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 Donation 5 Other (Specify) 4/22/08 Bayview Crematory Baltimore, Maryland 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. Many 3204 Mountain Road Pasadena, Maryland 21122 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS hysician /Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and is the burial-trans Due to (or as a consequence of): Physician/Medical the attending population of the design of th as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) s been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed? res 2 No certificate 1□ Yes 1 Yes To the nospital or Attending Frigstcian:
within 24 hours after death.

To the Funeral Director: After this certific
completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mi Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospiral Drive Glen Burnie mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 2:08 SCOTT 2008 JOHN 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1512 TY SOHNS TOPAZNS/TUSPZTOL If Under 1 Year TZMORE 8. Date of Birth (Month, Day, Year) July 7, 19 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Sex 11 M 2 □ F **Funeral** Days Months Min. Hours 226-68-6816 59 Virginia 1948 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Virginia Stafford Director Fredericksburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 102 Old Landing Court 22405 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [2] No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "n any Injury or other transmets." College (1-4or 5+) Elementary/Secondary (0-12) Judge State of Virginia 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Boykin John W. Scott ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 Old Landing Ct., Fredericksburg, VA 22405 Alda L. White (Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mercer Crematory 4/21/08 Fredericksburg, VA 4 ☐ Donation § ☐ Other (Specify) 22. Name and Address of Facility Bailey Funeral Home 1207 White St., Fredericksburg, VA 22401 21. Signature of Funcial Service License ennic Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hours ULMONARY EMBOLEST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 1☐Yes 2☐No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?

Ves 2 No 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificar completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

APR 22

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HASBCHULL a2. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

145 ST BALTEMORE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JOSEPHINE 2 008 6:57 PM Physician APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MARBO If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 24, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2X F Min. 77 198-22-9382 Aug. Director PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2X No MD Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Mapledale Avenue 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏝 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Giacomino Mazza Theresa Cerzullo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank M. Sobiski/Husband 20 Mapledale Avenue Glen Burnie Maryland, 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 23, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2008 4 Donation 5 Dother (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 MUNICIPAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner YOSARCOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ■ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, signe I be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 🔀 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) APRIL 19 2 GAGARIN 29c. License number 29b. Signature and title of certifier RESO01

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State Registrar

31. Date filed (Month, Day, Year)

SOUTH

HANOVER STREET

an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DMITRIGAGARIN, MD

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year \mathbf{P}^{M} Betty Schneider 2008 4:30 /Medical 16, April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕅 F Director 215-30-9574 Usual Residence of Decedent 7/11/34 Maryland 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examinar must be notified at Directo 1. Yes 2 □ No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1913 McHenry Street 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Richard H. Wilson Christine Hetmanski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau <u>Alan Schneider</u> 1919 McHenry Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4/21/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or conshock, or hear failure. List on lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physiclan and for use as the burlal-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Records, P.O. Box 68760 After this certificate has Division of Vital BETTY death. To the Hospital o within 24 hours aft To the Funeral Di

with the Maryland

filed within 72 hours after

21215-0036

Maryland

Baltimore,

APRIL

State

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2008 INCEN /Medical 4a. Facility Name (If not institution, give street and number, 4b City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth
(Month, Day, Year)
5-/2-/9 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2 □ F Months Days Hours 217-52-6251 1950 Director ary and Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h. Count 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 Pres 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 629 21212 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) echanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Pages 1 and 2 should be finent of Health and Mental Figure 27 is marked of Scutt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Scutt Almenia lumbridg Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Probable myocard /Medical Due to (or as a consequence of): Examiner Due to for each consequence office Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) physician by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Por in the past 12 months? Day 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed certificate 1∐ Yes 2 Mar No or Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, [Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2000 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ≥CER/Outpatient 3 DOA Certification: To 1 Tes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Feath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 = rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

APR 22

3 Registrar's Signature

Doulevand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 16 H **Physician** ons 2008 4pi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner tor His Make Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 5. Social Security Number Philadelphia PA Near) Days **Funeral** 9/29/2 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director ton 10g. Citizen of What Country? 10f. Zip Code 2108 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deves 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes No Maryland 21215-0036 Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be NORD ပ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 20c. Location - City or Town, State 3 ☐Removal from State Frans rewerall 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice FUENS MU death. Do not enter the mode of dying, such as cardiac r respiratory arrest, 23a. Part1 Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final Coponse hous Syndrome **Physician** Inflammatory disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-trar Due to (or as a consequence of): IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Records, 2 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 2 ER/Outpatient 3 DOA 1 Inpatient ပ 1 ☐ Yes 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Hospital or Attending | 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 17th, 2008 Dec 56607

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH ANGELO, #205, No 602 S. HTW. COD ROAD, BEL AIR MD 21014

MD

2008

32. Registrar's Signature

08-02940 John William Th		Please Type or Print in Black Indelible Ink.			ble.	
John William Th		State of Maryland / Department of Fleat		ygiene	. 200	8 1300
		Registrar Certificate of Deal	in	Reg.	. No. 400	0 , 0 0 0
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month E April 15, 200	Day Year	3. Time of Death 0507 hrs
Wir-Cai Exami	ICI	John William Thomas JT. 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of Death	
			more		4c. County of Death	
Euporol	-		der 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. Bir	tholace (State or
Funeral Director		Month		_	Foreig	in .
	-	217.76.2676 12M 2 F 37 Yrs.		16.90	·1970 00	untry) MI
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
- G. C. C.		MD Baltimore	9			1 Yes 2 No
rylan a-f sl	흥		p Code	100	. Citizen of What Cou	ntry?
e Ma or 28	Director		1225		IIC A	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	등	3113 0 311ee1	lent of Hispanic Origin? (Sp	pecify Yes or No-	14 Race - Ameri	ican Indian, Black,
items ath	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spec	cify Cuban, Mexican, Puerto		White, etc.	
fler d			2 No specify:		Specify: B	ac K
urs af	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua	I Occupation (Give kind of v		16b. Kind of Business/	Industry
72 ho	e e	Elementary/Secondary (0-12) College (1-4 or 5+)	orking life. DO NOT use reti	red)		
036 ithin ne.	Completed	12th Shipp	ina Cler		Barnes	3 Noble
5-0 led w other		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname)	
21 be fi ental	Be	John W. Thomas, Sr.	190 Jer	aldine	. Foster	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Addres	SS (Street and Number or I	Rural Route Numb	er, City or Town, State	
ME 3 Salth at an 27 aum 27		Latonya T. Thomas/Wife 137138t	in Street B			<u> </u>
or tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place	e)		20c. Location - City or	
Page Page nent:		4 Donation 5 Other Specify: Parkwood Ce	metery 4.	31.3008	Baltimo	re.MD
alti rmit spartn port jury	- 1	21. Signature of Funeral Service Licensee 22. Name and	d Address of F cility V	ann C.G	reene Fur	veral services
E 2 2 2 E		Vaugna C. Theene 14905	metery 4. d Address of Ficility (a) York Pad Bo	Mimore	WD SIS	.12
Physician	l	23a. Part I. Ent the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
'Medical xaminer	i	Immediate Cause (Final disease a. Gunshot wound of head				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ا ۾	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	틝	(Disease or injury that initiated				4 1
1/ 5 5	Examiner	events resulting in death) Last Due to (or as a consequence of):			<u> </u>	
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certi	lë.	past 12 months? 1 Live birth 2 Fetal death 2 Fetal death 4 Pregnant at time of death 5 Other (Sp		ancy	Monta	Day real
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O. In the latter tached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
P. P. res th	d by			1 Yes	2 🗸 No 3 Pro	bably 4 Unknown
ds requir	Completed			24a. Was ar		utopsy findings available
col e has e has	립			autops	ned? death?	completion of cause of
Re ifficat		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Y	es 2 No
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be an Insertor: After this certificate has been signed by the attending physicited in by the funeral director, page 2 should be detached for use as the buri	Be	examiner? Hospital: Insertion 3 P EB/Outpetient 3	Othor		Residence 6 Othe	
n of V ing Phy After thi funeral d	의	1 ✓ Yes 2 No I Impatient 2 ✓ ENJOurpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?		ow injury occurred	
on G	Certification:	1 Natural 5 (Month, Day, Year)	1 Yes 2 X No	ı	shot self	
Atter	ۊ	2 Accident Investigation 28e Place of Injury - At home farm, street, factor	ry, office building, etc.	28f. Location (St	treet and Number or R	ural-Route Number, City
Div lalor safte		Suicide Could not be determined (Specific) residence	y, emec banding, etc.			ural-Route Number, City Indan AVE
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director and the formal director and the funeral director an	اچّ	29a. Certifier	ne time, date and place, and	Baltimo		ted.
the I hin 2. the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in n				
To with To con	Me	and manner stated.	9c. License number		29d. Date signed (Mo	
		Done my Dincol IMD	O.C.M.E.		April 15, 2008	
20		30. Name and address of person who completed cause of death (Item 23a)			-	
		·	n Street, Baltimore, M	ND 21201		
91	ate)			
Regist		31. Date filed (Month, Pay Year) 2 2008 32. Figistrar's Signature	F			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** eanor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE owson If Under 1 Year | If Under 24 Hrs. Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days Hours Min Director Yania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director TIMOR LTI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or Items 23a or 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 ☐ Widowed 4 💆 Divorced other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mar Jennedy 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be illiers 2 +10WERS cordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licenses BACTIMORE, MD 21234 Evans Fineral Chapel & Cremation 23a. Part1. Enter the dilease, or a mplications that reused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart fail are. List may one cause on just line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local in the class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗆 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 25201 18,2008

State Registrar

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 2 2 2 Charles St.

32. Registrar's Signature

Balto. md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 4a. Facility Name (If not institution, give street and number) Z008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Bulhnive H Bayriew Medica Year If Under 24 Hrs. Date of Birth (Month, Day, If Under 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) **Funeral** Days Min. Months Hours 12M 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 □ No MO lamare Funeral Director Ruth more 10g. Citizen of What Country? 10e Street and Number United States 21206 5411 emmell 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Father's Name (First, Middle, Last) Inform n's Name/Relationship (Type. Print)
Stephonie 3altimore, Burial 2 ☐ Cremation 3 ☐ H 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter k, or heart failure. List only one cause on each line. 23a. Part Enter the dis strock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sepsis an eto (or sa consequence of): **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \(\times \) Yes \(2 \times \) No 3 DEctopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an autopsy performed? Yes 2000 1□ Yes **Division or Vital** To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Mpatient 2 ER/Outpatient 3 ☐ DOA Medical Certification: To Director: After th 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide within 24 hours after d To the Funeral Direct completely filled in by determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifia eted cause of death (Item 23a) (Type, Print) 30. Name an address of person who con 0 MIrnova 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

"natural", or Baltimore, Maryland 21215-0036 than permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other trainmant.

WHITE, LEMUE

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician To the Hospital

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:58 AM APRIL 2008 emuel 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SAMARITAN BALTIMORE HOSPITAL 9. Birthplace (State or Foreign Country)
South Cotoling if Under 1 Year | if Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 □ F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Boltimore Md Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23a or USA 4400 tranevia 21206 DRIVE Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: BLACK ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) odd Elementary/Secondary (0-12) College (1-4or 5+) Solos Employed r's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EUKLENA EARL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TRancoiA SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation M+ Carmel Cometere 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio BROUNURUS Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a Part1. Enter the dise shock, or heart failur mmediate Ca se (Final SEPSIS SEVERE disease or condition resulting in death) PNEUMONIA INFECTION TRACT URINARY sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. □ lonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No HYPERTENSION MELLITUS 24a. Was an autopsy DISEASE 20 CORONARY ARTERY 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 1 Dinpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD RESOUD APRIL, 11,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 01239 5601 LOCH RAVEN BLUD. MAWALE KOSHAN 32. P gistrar's Signature 31. Date filed (Month, Day, Year) Seewa APR 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

		1	For State of Maryland / State of Maryland / Registrar		ificate of E			Reg. No. 1	2000	13012
PI	hysicia		1. Decedent's Name (First, Middle, Last) Selma Beverly Merlis Weisel				2. Date of De April		:008 ^{Year}	3. Time-of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. C	ounty of Death	
. <u>.</u>	xamin	51	Manor Care Potomac		Potomac			Mon	tgomer	у
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Dallillore, Marylaring 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ar, or items xa⊡iner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
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od 2 shou	27 Is mar r traumat		19a. Informant's Name/Relationship (Type. Print) Steven J. Weisel / Son	19b. Mailing 5007	Address (Street a Battery	and Number or Rui Lane, Bet	al Route Numi :hesda,	oer, City or Mary	Town, State, 2 land 20	(ip Code) 1814
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allillor mit. Pages partment of	rtant: njury		4 □ Donation 5 □ Other (Specify) Montgot 21. Signature of Funeral Service Licensee			Inc. Apr.				
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O. BOX of	been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)	′		2	3d. Date of del Month	livery Day Year
ords, P.O	igned by be deta	by	Part II. Other significant conditions contributing to death but not resultin Diabetes Mellitus	ng in the un	nderlying cause giv	en in Part I.				o the cause of death?
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<u>a</u>	has je 2	Completed	Hyperthyroidism				aut	opsy formed? 211 No	prior to death?	completion of cause of 2 □ No
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Of V	.s. . .	70	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER.	· · · · · · · · · · · · · · · · · · ·		4 Et Nursing H	ome 5 ☐ Re			ecify)
on o	After		1 ☑ Natural 5 ☐ Pending (Month, Day Year)	8b. Time of Injury	Wor	yat k? Yes 2∐No	280. Describ	e now injury	y occurred	
DIVISION I or Attending after death.	Director: Jin by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre		100 2 110	28f. Location City or 7	(Street and own, State	d Number or R)	ural Route Number,
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: A completely filled in by the fi	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time	ne cause(s) e, date and	and manner a I place, and du	s stated. e to the cause(s)
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	,0		30. Name and address of person who completed cause of death (Item 23 Kirti Vohra, M.D., 7710 Bradley I	3a) (Type,	Print)		and 20			
	- C1	ato	04 Date Stand (Month Day Year) 32 Phoistrar's Signatur	re		ua, Malyl	.a.i.u 20	017		
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08-03007 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gordon P. Weedon, Jr. 1- For State Certificate of Death Reg. No. Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 18, 2008 0030 hrs Examiner GORDON P. WEEDON, JR. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 232 Margate Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5-Social Security Number 216-86-1504 213 30 9314 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex **Funeral** oreign Min. Months Days Hours Director Country) MAY 29. 1963 1 XXM 2 44 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 XX No 28a-f shov ANNE ARUNDEL GLEN BURNIE other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 232 MARGATE DR. 21061 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 2XX No f Yes, Give Year 1 Yes 2 XX No specify: Specify: 4 XXDivorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Battimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Improvants: If them 27 is marked other than "hingy or other traumatic event, the Medical mingy or other traumatic event, the Medical SALES LUMBER INDUSTRY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY PATRICIA WIJORT GORDON P. WEEDON SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GORDON P. WEEDON. **FATHER** 232 MARGATE DR. . GLEN BURNIE. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X cremation 3 Removal from State BALTIMORE, MD BAYVIEW CREMATORY, INC. APR.22,2008 Donation 5 Other Specify: 21. Signature of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S. GLEN BURNIE. FINK M01148 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the iseale **Physician** Between Onset and failure. List only ne chuse on each line. Medical Death Fentanyl & clonazecem intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause mf (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical e attending physician a for use as the burial XUNPENDED X^M#9.BerFH.0879 5/14/08 TT / 23a,27,28a-f. perME,9880 6/11/08 TT Box 68760, 23d. Date of delivery IF FEMALE 3b. Was decedent pregnant in the Year Ectopic pregnancy Month Day Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ö 2 1 Yes 2 V No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available certificate has been coor name 2 should 24a. Was an prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Physician: Division of Vital Be Other; Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending Natural 1 Yes 2 X No Pending 24 hours after death. Director: Fnd 4/18/2008 Fnd12:30 am Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. X Could not be Suicide or Town, State (Specify) 232 Margate Dr. Glen Burnie, WD To the Funeral found at home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 18, 2008 Mus O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar Tasha Greenberg MD.

OCME

23462

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
April 19, 2008 **Physician** Elvera Louise Wiser 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 🗙 F Yrs. 90 Director 021-05-0101 Oct 20, 1917 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with t Hygiene. 2408 Forest Edge Court, #104M 21113 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 ₩idowed 4 Divorced Completed er than "natur the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary School System Pages 1 and 2 should be filed vent of Health and Mental Hygic ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Vallavanti Mary Bertoloni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Barbara Olson /daughter 2406 Forest Edge Ct., #104M, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem Apr 22, 08 Silver Spring, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licet 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. M01522 | 1411 Annapolis Road Odenton, Maryland 21113 hand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLENOTIC CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical the attending philosophia 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 No page 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide

State

To the Hospital within 24 hours a To the Funeral C Hospital

29a. Certifier

29b. Signature

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALLACE, MO, 9005

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D31136 APRIL 21, 2008

ICICARINE RD, BATIMORE, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2008 **Physician** Month ROBERT EUGENE ARMSTRONG APRIL 3. 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days 59 212-48-7762 Director 11/12/48 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 X Yes 2 □ No **Funeral Director** Virginia | Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. # 306 5500 Holmes Run Parkway 22304 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 Professor Defense of Health and Mental Hygis I Item 27 Is marked other i r other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Council Jordan Armstrong Gladys Taylor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Holmes Run Parkway Apt. Alexandria, Virginia 22304 Leslie Armstrong/ Wife # 306 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan 04/05/08 Alexandria, VA 4 Donation 5 Dother (Specify) 21. Signarthe of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 Ninth Street N.W. Washington, DC 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Due to (or as a Thise juence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner i or Attending Physician: The law requires that the death certificate be executed after death. Diffuse lavae

Due to (or as a consequence of): B-cell Cymphonia and resulting in death) Last Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No Director: , 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

filled in by within 24 hours at To the Funeral D Hospital Medical

State Registrar

and addres of person the completed hause of death (Item 23a) (Trot, Print) ELIZABETH KANG 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

APR 0 8 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0053281

10 CENTER DRIVE.BETHESDA, MARYLAND 20892

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed P.O. Box 68760, or Vital Records, Division

or Attending within 24 hours after death To the Funeral Director: completely filled in by the To the Hospital within 24 hours at To the Funeral C Hospital

MD 3800 RESERVOIR RD., NW, WASHINGTON, DC GREGORY GAGNON, 31. Date filed (Month, Day, Year) 32. Registrates Signature 2008 ▶

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MY

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

039954

29d. Date signed (Month, Day, Year)

20007

4-4-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State	State of Ma	ryland /	-	rtment of He tificate of D			giene Reg. No.	2008	13	018
			Registrar Decedent's Name (First, Middle, Las	t)					2. Date of De		Year	3. Time of	Death
	Physicia	_	Palmer	Earl		Ada	ms, Jr.		Month March			6:25	P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. C	ounty of Death	1	
			12028 Wishing W		NE			Cumberland If Under 1 Year If Under 24 Hrs. 8, Da			Alleg		or Foreign
	Funeral Director		728-03-9826	7. Age	(In yrs. last t	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 07/07/	Day, Year) Country)			Si i dieigri
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside C	ity Limits
	f sho	ò	MD Alleg	any		Cum	berland					1 ☐ Yes	2 ∑ No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?	
	th wit	alD	12028 Wishing					21502			USA	in a la dina	
õ	be filed within 72 hours after death with the Maryland Hyglene. d other than "natural" or items 23a or 28a-f show dother than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 1 Yes 2 □ N If Yes, Give	°1949 –	13. \	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No		ecity Yes or No Rican, etc.)		4. Race - Amer Black, White Specify:	e, etc.	
ეე ე	hours tural" al Exa	ed by	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	1952	a. Dece	lent's Usual Occupa	ation		16b. Kind	w d of Business/	hite ndustry	
-6121	within 72 ene. than "nal he Medio	Completed	(Specify only highest gra	de completed) College (1-4or 5-		(Give life. l	kind of work done a DO NOT use retired Pipefitte	luring most of work)	king		Railr	oad	
ס		Be Co	17. Father's Name (First, Middle, Last)				I DOIL OU	18. Mother's Nam	e (First, Middle	, Maiden S			
yland	should be nd Mental marked o	To B	Palmer	Earl			ams, Sr.		retta			asure	
Mary	2 8 8 8		19a. Informant's Name/Relationship (Type. Print)	1		g Address (Street a						
	es 1 and 2 should of Health and Men item 27 Is marke r other traumatic		Michael S. Adams 20a. Method of Disposition	/ Son	20h Place		8 Wishing		ne, NE.	, Cun	nberlan ation - City or	d, MD Town, State	21502
وّ			1 ☐ Burial 2 【 Cremation 3 ☐				sition (Name of matory or other place	1	00/0000		mberlar		
altimore,	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specifical Structure of Funeral Service Lice)		Cumbe		d Cremato Name and Addres						P.A.
g	perm Depa Impo any		Rome	adam	6		04 Decati			-		21502	
	* 5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	o not en	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approxima Interval Be Onset and	etween
	Physician	8	Immediate Cause (Final disease or condition			70	CAKCI	Noma			As	ow- 11	12av
	/Medical Examiner		resulting in death)	Due to (or as								0	1
	LXammer	<u></u>	Sequentially list conditions,	b. Due to (or as	a consequen	ce of):							
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ر ص	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequen	ce of):							
8760,	ate be nysicia he bui	dical		d									
တ	ertifica ing ph e as ti		IF FEMALE:	23c. If yes, outcome	of programmy	,					3d. Date of de	livon	
.O. Box	e death certifi the attending I ned for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)	<i>y</i>			Month	Day	Year
Д.	uires that the de signed by the a id be detached f		Part II. Other significant conditions	contributing to death b	ut not resultin	ıg in the ι	inderlying cause giv	en in Part I.	23e. Dio	tobacco us	se contribute t	o the cause of	f death?
rds	quires n sign ald be	d by							1]Yes 2[□No 3□P	robably	IIInknown
Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed								opsy formed?	prior to death?	utopsy finding completion of s 2 □ No	s available cause of
or Vital		Be C	25. Was case referred to medical					26. Place of Dea					
<u>-</u>	S is	To E	examiner? 1 □ Yes 2 Selvo		ent 2 ER			4 LINUISING F	lome 5 XRe			ecify)	
n o	ding Ph h. After th funeral		27. Manner of Dath 1 Natural 5 Pending	28a. Date of Inju (Month, Da		3b. Time of Injury	Wor	ryat rk? ∣Yes 2 ∐ No	28d. Describ	e how injur	y occurred		
Division	death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of inj	ury - At home	e, farm, s	reet, factory, office	163 2 110	28f. Location	(Street and	d Number or F	lural Route No	umber,
<u>≥</u>	al or A after al Dire	ertii	4 Homicide	building, et	c. (Specify)				City or I	own, State	,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	edge, dea n and/or i	th occurred at the ti nvestigation, in my	ime, date and plac opinion, death occ	e, and due to th urred at the tim	ne cause(s) ne, date and	and manner a d place, and du	is stated. ie to the cause	e(s)
	To th Within To th comp	Me	29b. Signature and title of certifier	<u> </u>			29c. Licens				te signed (Mor		
	3+		> Hod					26907		Ma	arch 29	, 2008	
	nas		30. Name and address of person who Harjit S. Si	dhu, M.D.,	925	Bish	op Walsh	Road, Cu	ımberlaı	nd, Mi	D 2150	12	
	st Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 1 2	2008 32. Egisti	rar's Signatur	k A	book						

			For State Registrar	State of Marylan	Cer	rtificate of		•	giene Reg. No. 2 ()	08 13019	
	Physici /Medi		1. Decedent's Name (First, Middle, L.	Lillian Beat Braxton	rice	Braxton		2. Date of De Month March	ath 31, Day 2008	3. Time of Death 10:00a M	
-	Examir		4a. Facility Name (If not institution, gi 7202 Whithorn Te			4b. City, Town, o	r Location of Death		4c. County of Death Prince Georges		
	Funeral Director			Sex 7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da June 1,	th ay, Year)	9. Birthplace (State or Foreign Country) Caplin, WV	
	e Maryland Ba-f show	ctor	10a. State 10b. County Maryland Prince		, Town or Local					10d. Inside City Limits 11☑Yes 2☐No	
	ath with th	ral Dire	10e. Street and Number 7202 Whithorn Te	rrace		10f. Zip Code 20735			10g. Citizen of W United	vhat Country? d States	
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Wedfeel Evanier coust by routified. injury or other traumatic event, the Wedfeel Evanier coust by routified.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 □ Yes 2 ☒No If Yes, Give Year or Dates:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. Black				
21215-0036	within 72 ho liene. r than "natur he Medical	ompletec	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give . life. L	dent's Usual Occup kind of work done DO NOT use retired grapher	pation during most of work d)		16b. Kind of Bu	ŕ	
Maryland 2	should be filed ind Mental Hyg marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Las Alger Henderson	t)	Sceno;	grapher	18. Mother's Name	e (First, Middle,		Transportation	
	1 and 2 shou Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship Harvey Braxton			•	and Number or Rur Terrace	al Route Numb		State, Zip Code)	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other th once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	⊒ neiliuvai iruili Siale I	ace of Dispos emetery, cren	sition (Name of natory or other place Memoria	ce)	Date		City or Town, State	
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic	way MOLO	85 \$		boro Pope			Md. 20747	
	Physician /Medical		23a. Thin Eleter the discusse, or conshock, or heart failure. Elst only Immediate Cause (Final disease or condition resulting in death)	a ALZHEIMER"S I	EMENT		ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertified Classe (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ b. Due to (or as a consequ c. Due to (or as a consequ d.	ence of):						
O. Box	The law requires that the death certific ate has been signed by the attending pi age 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □	Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day Year	
rds, P.	v requires that been signed b should be dete	by	Part II. Other significant conditions	contributing to death but not resu	lting in the un	nderlying cause giv	en in Part I.	- 14		ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	
al Records,		Completed						24a. Was autop perfo 1 🗆 Yes	osv n	Nere autopsy findings available brior to completion of cause of leath? □Yes 2 □No	
Vital	9 S S	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 ☐ Inpatient 2 ☐ I	- D/O to the skip of	t 3 🗆 DOA Oth	er: Deatl				
1 of	iding Phys th. : After this : funeral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at		dence 6 Othe		
Division of	or Attending after death. Director: After in by the fune	Certification:	1 ★Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not to 4 Homicide determined	e 290 Place of Injury At hor	Injury me, farm, stre		Yes 2□No	28f. Location (S City or Tov	Street and Numbe vn, State)	er or Rural Route Number,	
	Hospital 4 hours a Funeral rely filled	Medical Ce	29a. Certifier 1 A Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my knov miner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	inner as stated. and due to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	I (Month, Day, Year)	
			1 TN jum	Y		D00586	86	A	April 2,	2008	
12	/5/		30. Name and addres person who Thu Nguyen, MD 61	completed cause of death (Item 04 01d Branch A		,	1s. Md 2	0748		proceedings.	
	Sta Registr	te	31. Date filed (Month, Day, Year) APP 6 8 7008	32. Registrar's Signati		-mpro IIII	20, 114, 2	.0740			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fth 8879 5-22-08 vt. State of Maryland Phepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician FLORA Η. BRUNSON 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGE S

9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Hours Min. AUGUST 11 1919 NORTH CAROLINA 88 Director 241-11-1314 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ▼Yes 2 No Director BOWIE PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 USA 3506 BURLEIGH DRIVE Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 Yes 2 No Specify 3 Widowed 4 Divorced "naturai" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 1008. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname)

MCCOY 17. Father's Name (First, Middle, Last) Be WILLIAM E. HUNT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s 3506 BURLEIGH DRIVE BOWIE, MARYLAND PAMELA BURKE/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CAMDEN, NORTH CAROLINA 4/12/2008 HUNT CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final **Physician** 4 doys disease or condition resulting in death) /Medical Due to (or as a consequence of): Renal failure Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Embolic Stroke The law requires that the death certificate be executed Acute that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy this certificate 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

FARHADJAMALI ND 31. Date filed (Month, Day, Year) APR 0 8 LUUU

29b. Signature and title of certifier

arway

32. Registrar's Signature

and manner stated.

29c. License number 8 213

cause of death (Hem 23a) (Type, Print) Center Drive Greentelt MD 20770

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 2008 Year **Physician** April PM Sarah Bernettia Bradbury 10:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Hospice House Tallot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF Yrs. Director December 27, 1945 Maryland 214-46-2533 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Maryland Caroline Preston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 7812 Shore Drive 21655 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Caucasian 3 Widowed 4 Divorced Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Marina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Efford Mary Belle Bailey Chester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7812 Shore Drive, Preston, Maryland 21655 Frederick W. Bradbury Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 4/11/2008 Dover, Delaware 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death Spe to (or as a consequence of): Immediate Cause (Final Physician as cenand disease or conditior resulting in death) /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 □ No ed by the detached 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 05 016 Hospital: 1 🗌 Yes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Records, P.O. or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Division

Maryland 21215-0036

Baltimore,

Box 68760.

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 1 2008

29b. Signature and title of certifier

10ben

Name and address of person who comp



eleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

KB 5

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1)0009

29d. Date signed (Month, Day, Year)

0 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
RegistrarAmend#'s 10e-10f.PerInformantPCC4-16-85tificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Melvin Joseph Blair, Sr. ам /Medical April 2008 10:50 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9112 Locksley Rd. Prince Georges Ft. Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 1 / 3 5. Social Security Number Sex r M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 69 577-46-8532 Director Washington, D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show Maryland Prince George's d other than "natural", or items 23a or 28a-f shov event, the Mucical Examiline must be redilled at Fort Washington Director 1 Yes 2 No Florida Palm Coast 10e. Street and Number 9112 Locksley Road 10f. Zip Code 10g. Citizen of What Country? 20744 32164 48 Westgrill Dr. United States Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give Specify \$ Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Department of Navy s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th Facility Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Blair Helen Goff ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau Melvin J. Blair, Jr. Son 9112 Locksley Rd. Ft. Washington, D.C. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Suitland, Md. 4-7-08 4 ☐ Donation 5 ☐ Other (Specify). 21. Signature of Funeral Service Liq 22. Name and Address of Facility Alexander S. Pope PA. 5538 Marlboro Pike/Prorestville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy Physician; The perform certificate 2 🖾 No 1 □ Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Son s Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1X Natural 5 Pending death. ours after death.

Neral Director; /
filled in by the fi 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a Medical 29a. Certifier 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 April 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Martin Weltz MD

31. Date filed (Month, Day, Year)

APR 0 8 2008

7525

Greenway Center Drive Greenbelt, Maryland 20770

		•	For State Registrar		St	ate of	Marylan		artment rtificate				lental Hy	giene Reg. No	ZUU	8	13023
			Decedent's Name	(First, Middle	e, Last)								2. Date of De	ath		·	3. Time of Death
	Physicia /Medic		CURT	7.5	BIR	ctt	JR						4	Da	32	ear	2756 M
	Examin		4a. Facility Name (If	not institution	- 4	2 /			4b. City, 1		Location	of Death			. County of		50
			5. Social Security Nu	7a	6. Sex	£ 1	Age (In yrs.	last hirthday)	BEL If Under		If Under	r 24 Hrs.	R Date of Bir	- V	will'		
	Funeral Director		218-34-32		1 X M		69	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 10/2/1	938) "	Cour	nlace (State or Foreign htry) MD
			Usual Residence of	Decedent									-0/ -/ -				
	anylan show	_	10a. State	10b. County				y, Town or Lo								1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-1	Director	MD		ester		0c	ean Ci						10- 0	N' () 0 PL		
	with t	급	13002 Rig		dan D	Ч			10f. Zip					US	tizen of Wh `∧	at Cour	itry?
	be filed within 72 hours after death with the Maryland lat lygiene. od other then "naturel", or Iteme 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral	11. Marital Status	giii Ki	12. W	Vas Deced	lent Ever in U	.S. 13.	Was Deced	ent of Hi	ispanic O	rigin? (Spe	ecify Yes or No	7	14. Race -		
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lan	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Market aumatic event, the Market aumatic event, the Market event.		19a. Informant's Na						•				al Route Numb	-			
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Baltimore, Maryland 21215-0036	Pages 1 nent of P nnt: If ite		20a. Method of Disposition 1 X Burial 2	Cremation		val from S	tate	Place of Dispo cemetery, crei	matory or ot	her plac					ocation - Ci		
ij	it. Pa rtmer rtent: njury		4 ☐ Donation 21. Signature of Fur				EV	ergree			•		′2008		lin,		
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00 S O	e dea the et	Completed by Physician/Me	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4		nt at time of d		Other (spe						Month	1	Day Year
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シンナン Sion	ttending Physician: death. stor: After this certifice t the funeral director, f	catl	2 Accident 3 Suicide	investig 6 ☐ Could	not be	Diago	of laines. At h		M		Yes 2		284 Leastine	(Ctrant a	and Alexandras	0. Pur	al Route Number,
D. T.	or A efter Direction by	Certification;	4 Homicide	determ	ined 20	buildin	of Injury - At high etc. (Specif	(y)	eet, ractory	, опісе			City or To			OI HUIZ	ar noute wullber,
25	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	alC	23s Certifier	Gertifyin	ig Physiciai	n: To the !	past of my kno	met, egbalwo	h oppured s	at the tar	ne, date a	nd place:	and due to the	causa(i	i) and man	10F 3S 5	tated
200	the Ho nin 24 the Fu	edical	(Check only one)	2 Medical	Examiner:	On the ba	sis of examina er stated.	ition and/or in	vestigation,	in my of	pinion, de	ath occurr	ed at the time,	date an	id place, an	d due to	o the cause(s)
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	BA 5+1		30. Name and address	ess of person	two comple	M()	-	n 23a) (Type, BROA		1.	BER	LIN	1, MI	21	811		
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	Registr	ar		APR 0	8 2008		letur	D. P	Mark.								

Certificate of Death

Reg. No.

Year

0.0 04 8×5

State

31. Date filed (Month, Day, Year)

MAR 2 8 2008

30. Name and address of prison who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Juan Arrisueno, M.D., 902 Seton Drive, Cumberland, MD

21502

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 2008^{eai} Mary Ellen Beyer 6:30P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Silver Spring if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 1, 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 □ M 2 🔀 F 384-18-3491 Toledo, Ohio Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2 X No 10f. Zip Code 20705 10e. Street and Number 10g. Citizen of What Country? 11334 Montgomery Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married X Married altimore, Maryland 21215-0036 1 □ Yes 2 No White Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+3+ Housewife lown home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sandoz Kathryn Driscoll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 11334 Montgomery Road Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type. Print) George L. Beyer, Jr. -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State George Washington Cemetery 4/11/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licenses Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arrythmia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. if yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Congestive Heart Failure; Adison's Disease 1 Yes 2 No 3 Probabiy 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s perform rmed. 2 □XNo 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) X No 1 🗌 Yes ٩ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 14∑ Natural Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

APR 0 7 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raman Tuli, M.D. 3503 Perry Street, #B Mt. Rainier, Maryland 20712

and manner stated.

ORIGINAL

29c. License number

D19609

29d. Date signed (Month, Day, Year) April 2, 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death April **Physician** Day 2008 Year 2, Louise R. Meyers Beauregard 1:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M X X X 139-16-2679 85 23, 1922 New Jersey June Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director XXYes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Glenwood Street Apt 607 21401 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 □Yes 2XXNo 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes ZayTNo Specify. à Specify: White 3 Widowed XX Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Christian Services Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Edwards Myers Celia Anna Kaslow ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland P. Beauregard / Son 316 Stream Road Ripley ME 04930 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2008 Baltimore Crematory Baltimore, Maryland 21. Signature of Funeral/Service 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mick 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Schonn disease or condition resulting in death) Que to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The

and burial-trar attending physician the use as for the signed by t page 2 should has certificate director, this funeral After within 24 hours after death

To the Funeral Director: filled in by npletely

Funeral

Director

28a-f show

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or items 23a

"natural"

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than '

Department of Health Important: If item 27 any injury or other to once.

Physician

/Medical

Examiner

72 hours after

Maryland 21215-0036

Baltimore,

event, the Medical Examinar must be notified

Registrar

NOCK 2m

29b. Signature and title of certifier

(Check only one)

31. Date filed (Month, Day, Year) State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: 10 the best of my animeted, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, P

2008 APR 0 7

001 strar's Signature

Medical

Division or Vital Records, P.(requires that th
Rec	The law
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vision o	Attending Ph ir death.
S Di	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.
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	1 - State Registrar			Cer	tificate of	Death		Reg. No.	0 100
an al	1. Decedent's Name (First, Middle, James	Last) William	n	Bar	rick		2. Date of Dea	5 Day 2008 Year	3. Time of Dea 1:35P
	4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of Death		4c. County of Dea	ith
	2506 Coach Hou 5. Social Security Number 218–38–2212		e (In yrs. las 65	t birthday) Yrs.	Frederic If Under 1 Year Months Days	k If Under 24 Hrs. Hours Min.	8. Date of Birt	y, Year) C	thplace (State or Fo ountry)
	Usual Residence of Decedent		10-01-7				Nov. 28	,1942 Mar	yland
5	10a. State 10b. County Maryland Freder	f ale	10c. City, 1	deric					10d. Inside City L
Directo	10e. Street and Number	ICK	rie	delic	10f. Zip Code			10g. Citizen of What C	24
	2506 Coach Hous	o May 3-D			2170	2		USA	
Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V		L dispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No	- 14. Race - Ame	
by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	No		☐ Yes 2☐ No	Specify:	o Rican, etc.)	015	white
ted	15. Decedent's	Education	- 1	16a. Deced	ent's Usual Occup	pation		16b. Kind of Business	
Jple.	(Specify only highest	Gollege (1-4or 5	i+)			during most of word d)	king		
Completed				Plann	er-Estim			U.S. Gove	ernment
e R	17. Father's Name (First, Middle, L	ast)	_				ne (First, Middle,	Maiden Surname)	
9	Charles 19a. Informant's Name/Relationshi	n (Time Print)	Barr		a Addrage (Street	01ive	ral Pauta Numb	Hauve: er, City or Town, State,	
1	Betty Jean Barr					use Way 3		derick, MD	
Ť	20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of natory or other place	1	Date	20c. Location - City or	
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		1		- ,	1.100	/2008	Two dowd old	MD
ı	21. Signature of Functal Service L		IL IIL.		. Name and Addre			Frederick, Funeral Ho	
	200UKIU	Ju-		16	21 Oposs			derick, MD	
al Examiner	Sequentially list conditions, if any, leading to immediate bause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as							
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	2 Fetal de	eath 3	Ectopic pregnancy	у		23d. Date of de Month	elivery Day Yea
hys	9 Unknown	9□Unknown							
ò	Part II. Other significant condition	s contributing to death bu	ut not resultin	ng in the ur	derlying cause giv	ren in Part I.		obacco use contribute t Yes 2 <mark>≓</mark> No 3□ P	o the cause of deat Probably 4 □Unk
Completed								an 24b. Were a prior to death?	
Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	one)	
2	1 ☐ Yes 22 No	Hospital: 1 Inpatie			t 3□ DOA Oth	4 ☐ Nursing H	1111	dence 6 ☐Other (Spe	ecify)
<u></u>	27. Manner of Death 1 ■ Natural 5 Pending	28a. Date of Injui (Month, Day	ry y Year) 21	Bb. Time of Injury	28c. Injur Wor M 1 □	ryat ńk? Yes 2 ∐ No	28d. Describe I	how injury occurred	
Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 290 Place of inju		e, farm, stre	eet, factory, office	res 2 NO	28f. Location (S City or Tox	Street and Number or R vn, State)	Bural Route Numbe
	29a. Certifier 1	Physician: To the best of xaminer: On the basis of and manner sta	f examination	edge, death n and/or inv	occurred at the tile restigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
edica					00+ 12	o oumbor		29d. Date signed (Mon	
Medical	29b. Signature and title of certifier	orho completed cause of diagram 32. Registr	>/	me	29c. Licens			1 0	2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Burns Isabelle Brennan 12:40 A M March 31, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 411 Independence Street Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 100 216-22-6451 Director 02/10/1908 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Allegany Cumberland MD "natural", or items 23a or 28a-f sh dical Examiner must be notified 1 ∑Yes 2 ☐ No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 411 Independence Street 21502 USA Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ۵ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 Is marked other than Tire and Rubber Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Robert Brennan Isabelle Brooks ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Brennan / Nephew 411 Independence Street, Cumberland, MD permit. Pages 1 a
Department of Hes
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery | 04/04/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Lice 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEFEBRO VARCULAR Accident **Physician** Sout 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIL 12 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the attending for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□1Jnknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? 1□ Yes 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 2 ER/Outpatient 3 DOA 1 Inpatient 은 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Box 68760, P.0. Division or Vital Records,

To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

nas

State Registrar

Medical

31. Date filed (Month 1 2008

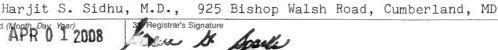
3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D26907

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:45 Mary Margaret Brode March 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-Frostburg Nursing & Rehab Center Allegany Frostburg If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F April 21, 1924 Maryland Director 83 215-14-6161 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 1 Yes 2 □ No Director Frostburg Allegany Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Honeysuckle Lane U.S.A 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 200 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) senior center unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia O. Wilhelm Adolph Francis Wagus ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21545-Mount Savage daughter 16732 Dutch Hollow Road Karen Sue Hook 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Bunal 2 ☐ Cremation 3 ☐ Removal from State March 29, 2008 Maryland Frostburg Frostburg Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6months mediate Cause (Final east Congestive Physician disease or condition resulting in death) Due to (or a da consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner and as the burial-tran Due to (or as a consequence of) IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9□ Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▶ No autopsy perform 2XNo 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21**X**No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide determined

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier worsock Shi MO 29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00055325 March 27, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP WALSH RD cumberland MD 21502 WONSOCK SHIN

31. Date filed (Month, Day, Year) State Registrar MAR 2 8 2008

29a. Certifier

Medical



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 9. 2008 9:20 A Alvin Leo Brill April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland New Hope Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 M 2 □ F 217-10-6948 87 09/07/1920 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 YYes 2 □ No Cumberland Allegany Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 113 High Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced White er than "nature the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. Plate Glass 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brill Lillian Μ. Harding James Alvin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eileen H. Brill / Wife Cumberland, Maryland 113 High Lane, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 04/12/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e-yih line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ted by the attending physician detached for use as the burian Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 3 □ Ectopic pregnancy 5 □ Other (specify) ___ 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Year Month Day in the past 12 months? ☐Yes 2☐No 9 Unknown after death.

Director: After this certificate has been signed by in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Assisted Hospital: Other: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 1 🕅 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a completely filled 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig April 9, 2008 D19318 3+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 517 Oldtown Road, Cumberland, MD 21502 nds Nagaratnam A. Ranjithan, M.D., 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State APR 0 9 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Henry Cosby 29 7:00pm 2008 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Under 1 Year Montogomery County General Hospital Montogomery If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months **1**√□ M 2□ F Hours Director 579-40-1317 1/14/1930 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examination in the profiled at ty Yes 2 □ No Director dcWashington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2701 Q. Street S.E. #102 20020 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Tree Sprayer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Marylou Baylor Henry C. Penn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2915 Capstan Dr. Upper Marlboro, Md. 20772 Leona Cosby/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/5/2008 Laurel, Maryland |Marvland National 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatur Funeral Service Lice e 701005 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part I. Enter the disease or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO PULMONARY ARREST /Medical Due to (or as a consequence of) Examiner RESPIRATION PNEUMONIA Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Examin sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes e Hospital or Attending Physiclan; 24 hours after death. 2 Funeral Director: After this certifical etely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2√∑No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D56691 April 1, 2008 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 12107 Heritage Park Circle Silver Spring, Maryland 20906 Ghousia Sultana MD

State Registrar

32. Registrar's Signat 31. Date filed (Month, Day, Year)

APR 0 8 2008

State of Maryland / Department of Health and Mental Hygiene 1 8

				e of Maryla	nd / Depa		t of H	ealth a	and M		jiene () lag. No.	08	130	32
	Physicia	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea	th Day 20	no Š ^{ear}	3. Time of 2:35	Death A M
	/Medic Examin	al	LAWRENCE F. CULLEN 4a. Facility Name (If not institution, give street as	nd number)		4b. City,	Town, or	Location	of Death	711 1121	-	nty of Death	10.30	
	Examin	E1	ATLANTIC GENERAL HOSI	PITAL			LIN		0411-			CESTER		-
	Funeral Director		5. Social Security Number 6. Sex 1XI M 20		s. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 7-26-1	Year)	PENN	olace (State o	IIA
	ס		Usual Residence of Decedent 10a, State 10b, County		City, Town or Lo	cation							IOd. Inside Ci	ity Limits
	Maryla fed at	to	DELAWARE SUSSEX		FRANKFO								1 ☐ Yes	
	3a or 28a	Funeral Director	10e. Street and Number 34613 EVANS ROAD			10f. Zip	Code 9945	5			10g. Citizen o US	of What Cou	ntry?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. Itsm 27 is marked other then "natural", or itama 23s or 28s-f show other treumatic event, the Mudical Experiment must be notified at	by Funera	1 ☐ Never Married 2 ☒ Married 1 ☒	s Decedent Ever in ed Forces? Yes 2 No es, Give ror Dates: 42-		Was Deced If Yes, spec				ecify Yes or No- Rican, etc.)	E	Race - Ameri Black, White, cify: WI		
Maryland 21215-0036	thin 72 hour e. en "natural Mudical Ex	Completed t	15. Decedent's Education (Specify only highest grade complete		16a. Dece (Give life.	kind of wo DO NOT u	al Occupa rk done d se retired	ation du <i>ring m</i> os	st of worki	ing		f Business/Ir	dustry	
121	lled wit lygien lher tha	Con	8 17. Father's Name (First, Middle, Last)		FARM	IER		18. Moth	er's Name	(First, Middle,	FARM Maiden Sum			
lanc	uld be f fental h rked of tic svs.	To Be	JOHN M. CULLEN							U DOORL				
Mary	12 should be f h and Mental b 7 is marked of Ireumatic ava		19a. Informant's Name/Relationship (Type, Print MILDRED E. CULLEN / W							FORD, D			Code)	
	s 1 and if Heelti itsm 27 other 1		20a. Method of Disposition	206	. Place of Dispo	osition (Na	ne of	T		Date		on - City or T	own, State	-
Baltimore,	permit. Pages i Depertment of H Important: if its any injury or of		1 X Burial 2 Cremation 3 Permova 4 Donation 5 Other (Specify)	from State C	AREY S	CEMET	ERY	14	4-9-0			FORD,	DELAWA	RE
Bal	Depermit Depermit September 1		21. Signature of Funeral Sorvice Vic	elson		13 TH	ATCHI	ER ST	, FR	VICES,L' ANKFORD	, DE.	19945		
	Pnysician /Medical		resulting in death)	Mysol	cotic	Card	de of dyin	g, such as	cardiac o	Cocee	rest,		Approxima Interval Bei Onset and	tween Death
	Examiner	lner	Sequentially list conditions b.	rue to (or as a cons										
0235	ate be executed hysicien and the burial-transit	ilcal Examiner	that initiated events c	Due to (or as a cons	equence of):									
70D: 0	Hospital or Attending Physician: The law requires that the death certificate to thours after death. Funeral Director: After this certificete has been signed by the attending physitely filled in by the funeral director, page 2 should be detached for use as the E	by Physician/Med	in the past 12 months?	es, outcome of pre Live birth 2 F Pregnant at time o	etel death 3	⊒Ectopic p ⊒ Other <i>(s</i> į		/			23d.	Date of delik Month		Year
6/2 1/08 ds, P.	quires that the signed by ald be detacted		Part II. Other significant conditions contribution	ng to death but not	resulting in the u	andertying (cause giv	en in Part	l.	1	obacco use d Yes 2□N		the cause of	death? Unknown
β 7/2 10 4/9 I Reco	The law requirelete has been sipage 2 should	Completed								24a. Was autor perfo	osy irmed?		opsy findings ompletion of 2 No	
DOB DOD Vital I	ilcian: certific rector,	Be	25. Was case referred to medical examiner?		EWOutpatie		Oth	.05		h Check only o		Other (Case	. .	
20	ding Physician: The i h. Affer this certificete ha funeral director, page	n; To	27. Magner of Death 28a	" 1 ☐ Inpatient 2 . Date of Injury . (Month, Day Yea!	28b. Time o		28c. Injur Wor	4 📙 N	iursing no	ome 5 Residence 28d. Describe			ny)	
XX.	death. ctor: Af y the fur	catic	1 Section 1 Section 2 Accident Section 3 Suicide 6 Could not be 280	. Place of Injury - A	1	М	1 🗆	Yes 2□]No	28f Location /	Street and N	umber or Ru	ral Route Nui	mber.
0,7,0 Div	al or Attends after death	Certification;	4 Homicide determined	building, etc. (Sp.	ecify)	neer, racio	y, onice			City or To				
21-12	To the Hoepital within 24 hours a To the Funeral (completely filled	Medical (29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examinar: On	To the best of my the basis of exam d manner stated.	knowledge, dea ination and/or i	th occurred	at the time, in my o	me, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause((s)
30	To the within 2 To the comple	Mec	29b. Signature and title of certifier	d mainter stated.		29	_	se number			29d. Date si	gned (Month	, Day, Year)	
			W Dane					282	69		4/	5 108	5	
5	T 12+	1	30. Name and address of person who complete William Bookslein	ed cause of death (Print)	Head	Lever	Fe	unck S	Tolan	1 De	1994	4
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si		borte	,	7				,		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1, Elaine C. Christian April 2008 3:31 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign Date of Birth (Month, Day, Yea 5-6-48 **Funeral** Days Hours 1 ☐ M 2 🔀 F 59 Maryland Director 214-50-0743 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Executors must be positived at Director MD. P.G. Clinton **X**Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 9606 Gwynndale Drive 20735 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hyglene important: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Exercises 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant F.T.C. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Ouillens Jean Belle P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrence Christian/Son 9606 Gwynndale Dr. Clinton, Md. 20735 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Glenwood Cemetery 4/8/08 Wash., D.C. `4 ☐ Donation 5 ☐ Other (Specify) If Funeral Service Licenses 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature N 814- Upshur Street, N.W. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed End Stage Renal Disease Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical SE IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 23d. Date of delivery 3 Ectopic pregnancy ō Month 4☐Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves X No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? __ 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🗶 No Hospital: 2 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death ↑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury s after decail and property after the fr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D46529 April 2, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Victor Onyejiaka, M.D. 7325A Hanover Parkway, Greenbelt, Md 20770 31. Date filed (Month, Day, Year) 32. gjistrar's Signature State Registrar APR 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 13034

For	State of Maryland / Department of Health a
State Registrar	Certificate of Death
Decedent's Name (First, Middle, Last)	

-	THE RESERVE
	Physician
	/Medical
	Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

6

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

1-	State Registrar				Ce	rtifica	te of	Death			Reg. N	No.		
	ecedent's Name	•	,							2. Date of D Month		Day Year	3. Time o	of Death
E	milda Ma:	rie—Rose	Roberts Co	stopoulos	;					April 2	, 20	08	9:05	a
4a. F	acility Name (//	f not institution	n, give street and nu	ımber)		4b. City	, Town, o	r Location	of Death		4	1c. County of Dea	th	
Holy Cross Hospital						Si	.lver	Spring	•		M	ontgomery		
5. Sc	ocial Security N	umber	6. Sex	7. Age (In yrs.	last birthday)	If Unde	er 1 Year	If Under Hours	24 Hrs.	8. Date of Bi	irth	9. Bir	thplace (State	or Fore
03	32-16-493	0	1 □ M 3/5 (F	83	Yrs.	Months	Days	Hours	Min.	Dec 24,				
Usua	al Residence of	Decedent		1				1						
10a.	State	10b. County		10c. Cit	y, Town or L	ocation							10d. Inside 0	
MD Montgomery Wheaton										1 □ Yes	s 24			
10e. Street and Number							10f. Zip Code					Citizen of What Co	ountry?	
4011 Randolph Road						20902						USA		
11. N	11. Marital Status 12. Was Decedent Ever in U.S. 13. \ Armed Forces?						Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					o- 14. Race - American Indian, Black, White, etc.		
1	□ Never Marri	ied 2□ Marr		XX No ive		_				nican, etc.)				
3	Widowed	4 Divorced	Year or I	Dates:		1 ☐ Yes	AL NO	Specify:				Specify: Wh	ite	
	(Spec	15. Deceden	t's Education st grade completed	1	16a. Dece	dent's Usu	ual Occup	ation during mos	et of work	ina	16b.	Kind of Business	/Industry	
EI	ementary/Seco			(1-4or 5+)	life.	DO NOT	use retire	d)	, or work	y				
		- , ,	2		Home	maker						Non Home		
17. F	Father's Name ((First, Middle,	Last)					18. Moth	er's Name	e (First, Middle	e, Maid	len Surname)		
A	rthur N.	Roberts						Marie	Rose	Couture)			
19a	Informant's Na	ame/Relations	hip (Type. Print)		19b. Maili	ing Addres	s (Street	and Numb	er or Rur	al Route Num	ber, Cit	y or Town, State,	Zip Code)	
Pł	nilip J.	Costopou	ılos /Son		7714 I	afayet	tte Fo	rest [rive,	#34, Ar	mand	dale, VA 22	2003	
	Method of Disp				Place of Disponentery, cre	osition (Na	ame of	ce)		Date	20c.	Location - City or	Town, State	
	1 ☐ Burial 2x4 4 ☐ Donation		3 □Removal from	i State	copolita	_		· .	hor 9	2008	Alex	kandria, V7	Α.	
-	Signature of Fu			FEG								ins Funeral		nC-
		ب م د لام)([()	20.								g, MD 20901		
238	Part1 Enter ti	he disease or	cook lie tions that	caused the deal								,		ate
			convilications that only one ause on	each line.	in. Do not on	itor the me	ao or ay ii	ig, outil ac	ouruido	or respiratory	arrest,		Approxima Interval Be Onset and	etween I Death
dise	nediate Cause (ease or conditio ulting in death)	rinai n	a. Uppe	r gastroi	ntestin	al_ble	ed (h	emorrh	age)		_		1 week	
1030	anding in deading		Due to	(or as a consec	quence of):									
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if an	uentially list con ny, leading to im se. Enter Unde	nmediate erlying	Due to	o (or as a consec	quence of):									
that	ise (Disease or initiated events ulting in death) I	3	с							_				
1630	ining in death) i	Lasi	Due to	(or as a consec	quence of):									
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	in the past 12	X No		gnant at time of		Other (s		,				Month	Day	Year
	9 ☐ Unknown									T				
Part	II. Other signif	ficant conditi	ons contributing to	death but not res	sulting in the s	underlying	cause giv	en in Part	I.	23e. Did	tobacc	co use contribute t	to the cause of	death?
	Dementia	a								1 [] Yes	3 No 3 □ P	robably 4]Unkno
	Hyperte	nsim								24a. Wa	s an	24b. Were a	utopsy finding	s availa
										aut	opsy formed	prior to	completion of	cause
OF '	Depress:		ıt									No 1 ☐ Ye		
	Was case referexaminer?		Hospital:		3 5510		Oth	er.		h (Check only				
	1 ☐ Yes XX Manner of Deat		<u>' X</u>	Inpatient 2 e of Injury	ER/Outpatie		JOA	4 LI N				6 Other (Spe	ecify)	
	1 XNatural	5 Pendir	ng (Mo	nth, Day Year)	Injury		28c. Inju			Zou. Describe	II WOII E	njury occurred		
1	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	a attetue att		M I		Yes 2		004 /	(0)			
	4 ☐ Homicide	determ	nined 28e. Plac	ce of injury - At h ding, etc. <i>(Speci</i>	orne, rarm, st fy)	reet, tacto	лу, опісе			28f. Location City or T	own, Si	and Number or Fi ate)	ıuraı Houte Nu	ımber,
	-													
29a	. Certifier (Check only		ng Physician: To the Examiner: On the	basis of examin										e(s)
	one)		and ma	nner stated.										
29b	. Signature and		er 0			29	9c. Licens	se number			29d.	Date signed (Mor	nth, Day, Year)	
	Bare	rara	Suna	ich !	RSMI	ND	D0065	485				4-2-	08	
30.			who completed car									•	-	
1			500 Forest			,	, MD	20910						
	Date filed (Mon													
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** April 3, М Augustine S. Cook 9:00p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□ M 21 F Months Days Hours 110-14-0343 85 Nov. 3, Director 1922 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3156 Gracefield Road, #313 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Clerk/Typist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Sawitzki Anna Suizdak ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Joseph Kemp Cook/Husband 3156 Gracefield Road, #313, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April Date 9, N Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signal relof Funeral Service Licensee udien 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myelodysplastic Syndrone 6 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events Due to (or as a consequence of) Examine executed the burial-trans and resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician certificate be Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant atter 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Director: After th 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation 1X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

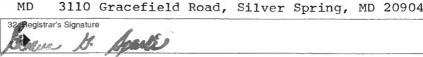
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 07 2008

Mark Parkhurst,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



D24093

April 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤍 🦳 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 200^{Y8ar} 03, 1:00 A Helen Clark 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Mar. 23, 1 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖸 F 203-09-1501 87 Ï921 Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Annapolis 1 √Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21403 931 Edgewood Road, Apt. 315 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🙀 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Honemaker Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Guri Anna Wasilick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 257 Cypress Creek Severna Park, MD 21146 Cynthia C. Metzger/daughter 20b. Place of Disposition (Name of cametery, crematory or other place Arlington National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) April 24, Arlington, Virginia 2008 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home re of Punera Service Licenses 495 Gov. Ritchie Ilwy, Severna Park, MD 21146 23a. Par 1. Int if the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 105 relation disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

permit. Pages 1 and 2 shi Department of Health and Important: If item 27 is m any injury or other traum

Physician

Examiner

Funeral

Director

?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Ive fical Evanthar must be notified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

Completed

Be (

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MD

that the death certificate be executed attending physician a for use as the burialbeen signed by the should be detached Hospital or Attending Physician: The law requires

page 2 s certificate

Division of Vital Records, P.O. Box 68760,

	EMALE:				
23b.	Was deci	ede	ent p	regnan	t
	in the pas				
	1 Tyes				
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art II. Other sig	nificant conditi	ions contributing	to death but no	t resulting in the u	inderlying cause o	iven in Part
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	20. 1140 0400	rolonou	to illegic
	examiner?		-
	1 ☐ Yes	2 100	
i			

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ano

annepoks MO 21761

after death

24 hours a Funeral L

within 2 To the I

filled in by

completely

Word m 31. Date filed (Month, Day, Year) APR 0 7 2008

201 Registrar's Signature

Registrar

		For State	State	of Marylan		artment of H		Mental Hy	gien	e	1.0	00-
-	_	Registrar 1. Decedent's Name (First, Middle	o Lant)		Ce	rtificate of	Death	2. Date of D	Reg. N	10. <u>4</u> U U O	I a Time o	U J
Physic	cian							Month	D	ay Year	3. Time o	M
/Med Exam		Jeanne Lois Amn 4a. Facility Name (If not institution				4b. City, Town, o	r Location of Dea	April April		c. County of Death	12:40	A
⊏xaiii	iner		Montgomer	,	20	Rockvill	۵			Montgomer	17	
Funera	ı	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days			rth	9. Birth	place (State	or Foreign
Directo		264-74-5268	1□M 2\XF	62	Yrs.	MOTITIS Days	Hours Will			1945 Mass		etts
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside C	City Limits
Maryla f sho ed at	٥			:								s 2 No
the N 28a-	Director	Maryland Montgo	mery	Gai	thersb	10f. Zip Code			10g. C	itizen of What Cou	ntry?	
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deatl	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin?	(Specify Yes or N		14. Race - Ameri		
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al y latter & I.K. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Books of the Mental should be shoul		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street				or Town, State, Zi	o Code)	
and and m 27		Lois H. Ammidov	<u>vn Hunter</u>	, siște	r 9208	Clematis	Court,	Gaither	sbur	g, Maryl	and 20	1882
Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show nother traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 XCremation	3 □Removal from	n State	cemetery, cre	sition (Name of matory or other pla	i	Date		Location - City or T	,	
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	200	21. Signature of Funeral Service	Licensee							lliams F		
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Physiciar		Immediate Sause Final									Onset and	tween Death
/Medica	•	disease or con 'tt' n resulting in death)		ng Cance								
Examine	r	Cognostically list conditions	h									
p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conseq	quence of):							
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death certific attending p	hvsician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn		7e				23d. Date of deliv	ery	
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rsicia s certi	o Be	examiner? 1 Yes 2 No	Hospital:]Inpatient 2□	ER/Outpatie	nt 3□ DOA Ott	ner.	eath (Check only		6 X Other (Spec	HOST	nice.
Attending Physician: The lav sr death. rector: After this certificate has by the funeral director, page 2:	7. 7	27. Manner of Death	28a. Dat	e of Injury	28b. Time o			28d. Describe			<i>ny)</i> 1105]	7100
ath.	atio	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	onth, Day Year)	Injury		Yes 2 No					
or Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	not be lined 28e. Pla bui	ce of injury - At h Iding, etc. (Speci	ome, farm, st	reet, factory, office	S#==2	28f. Location City or To	(Street own, Sta	and Number or Rui ate)	al Route Nu	mber,
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical		Examiner: On the							e(s) and manner as and place, and due		(s)
o the o the omple	Med	29b. Signature and title of certifie) Stated.		29c. Licen	se number		29d. [Date signed (Month	, Day, Year)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician Carlos F. Torres Costa 20:50 PM April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 110 M 20 F 581-68-7969 Director 1931 Puerto Rico Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No Maryland Harford Havre de Grace Director 10e. Street and Number 10g. Citizen of What Country? 34 Telstar Way 21078 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1950 Baltimore, Maryland 21215-0036 X Yes 2 No Specity: Puerto Rican If Yes, Give Year or Dates: Specify: Hispanic 1975 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0·12) College (1-4or 5+) U.S. Army Instructor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Govofredo Costa Julia Torres ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Stephanie Anderson-Costa (Wife) | 729 Ontario Street, Havre de Grace, MD 21078 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1 Depertment of H Importent: if its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) 4/10/2008 West Chester. PA 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Feneral Service Licens 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) sirutoru Physician /Medical Due to (or as a consequence of): Examiner mona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last D e to (or as a consequence of): The law requires that the deeth certificate be execu Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Division of Sir. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 Yes 2 No deeth. investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours el To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) H0066655 30. Name a address of pe who completed cause of death (Item 23a) Type, Print) JiON Aue Haure de Grace, MD 21078

DHMH 17 Rev 1/2001

State

Registrar

DO 501

32. Registrar's Signature

BONTREGER

2000

ENNITER 31. Date filed (Month, Day, Year)

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hs 23	era	11. Marital Status	ennsylvan	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or N			can Indian,
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lal ylallo 212 2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the N	To E	Mas	on Burr					Alber	ta Ruth l	Kelly Leas	se	
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To the Within	Me	29b. Signature an	d title of certifier	1/2				se number		29d. Date signe	f .	
		30. Name and ad	ess of person who	completed cause of d	eath (Item 23a	a) (Type,	Print)	36761 Jumbe	rela mal	MD	216	500
St	ate	31. Date filed (Mo	nth, Day, Year)	32 Registr	ar's Signature	29	. 69	AUTOR		1	413	300
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036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 or other traumatic event, the Medical Examiner must be notifiled at	by Funeral	11. Marital Status 1 X Never Married 3 □ Widowed 4 [12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 Yes		spanic Origin? (\$ n, Mexican, Puer Specify:	Specify Yes to Rican, e	s or No- etc.)	Blac	ce - Americk, White		
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	(Specify Elementary/Seconds	5. Decedent's Ed only highest gra ary (0-12)	ucation de completed) College (1-4or 2	5+)	life. i	kind of wo DO NOT u	ork done d use retired	luring most of wa	rking	Se	b. Kind of B curit	ies	-	chang
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	60 17	Completed by	CONGESTIVE		FAILURE				-			a. Was an autopsy performe Yes 21	d?	Were auto prior to co death? 1 Yes	opsy finding ompletion o	s available cause of
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)	Son Con	Ž	29b. Signature and title	hyl	- Y	9		1	c. License				Date signe		Day, Year,	
			30. Name and address SUSAN MILL		., 8218 W	ISCON	SIN AV		ВЕТНЕ	SDA, MA	RYLAN	D 208	14			
	Sta Registr		31. Date filed (Month, APR	Day, Year) 0 8 200	33 Registr	ar's Signa	ture	NE S								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** M Elizabeth Ann Cory April 4 2008 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

Solver If Under 24 Hrs. 13445 Locksley Lane <u>Montgomery</u> Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months Days 1 □ M 2√2 F 516-20-9856 84 Mar 10, 1924 Director Montana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or other traumatic event, the Region Exertives must be notified at any or other traumatic event, the Region Exertives must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 TYes XX No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13445 Locksley Lane 20904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
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Yes XX No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify. 3 ☐ Widowed 4 ♣ Divorced White Completed d other than "nature event, the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administ Assist/Homemaker Personnel / Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Gregory Ebert Irene Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Ann Cory /Daughter 13445 Locksley Lane, Silver Spring, MD 20904 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory April 7, 2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of color each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** congestive heart failure 5 years /Medical Due to (or as a consequence of) Examiner 23 years atherosclerotic heart disease Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown atrial fibrillation sustained Completed dementia coupled with alzheimer's disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 XNo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) and manner stated To the I within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0012121 April 7, 2008 30. Name and address of person when completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

MD 20906

George Sengstack 3929 Ferrara Drive, Wheaton,

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31. Date filed (Month, Day, Year)

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al Hygiene	2	0	0	8	1	3	0	L	2

		State Registrar			Cei	rtificate of L	Death		Reg. No.		
Physic	cian	Decedent's Name (First, Min						2. Date of Dea Month	Day	Year	3. Time of Death 4:15 p.M
/Med		4a. Facility Name (If not institu	Richard C. Chi			4h Ciha Taum az	Location of Dooth	April	02	2008 ty of Death	4.2 PW
Exam	iner		General Hospi		i	4b. City, Town, or	Olney		4c. Coun	Montg	Omery
Funera		5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	n		place (State or Foreig
Funera Directo	_	525-98-5279 Usual Residence of Decedent	1 ⊠ M 2□F	77	Yrs.	Months Days	Hours Min.	August 1		Coui	China
laryland show	7	10a. State 10b. Cour	,	10c. City,	Town or Lo					1	10d. Inside City Limits
he M 28a-f otifie	Director		ontgomery			7	Silver Spri		10g. Citizen o	6 18/h = 4 O =	
with a or	ä	10e. Street and Number				10f. Zip Code	00005		rog. Citizen o	U.S.	,
eath ns 23 must	eral	151.32 M	iddlegate Road	dent Ever in U.S	13	Was Decedent of Hi	20905	ecify Yes or No.	. 14. Ri	ace - Americ	
IOTC, INICITYICID A LAID-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Nover 3 Widowed 4 Divorce	Armed For 1 ☐ Yes If Yes, Giv	rces? 2 🔀 No re		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 2 No	n, Mexican, Puerto	Rican, etc.)	Spec	ack, White,	
72 h 72 h dical	ete	15. Deced (Specify only hig	lent's Education thest grade completed)		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of work	ing I	16b. Kind of	Business/In	dustry
within iene.	Completed	Elementary/Secondary (0-12			lite.				11 C	. Gover	nmant
I C I		17. Father's Name (First, Midd		5+		Computer	18. Mother's Nam	o /Eirot Middle			1ment
ylaill ould be f Mental b arked of attc ever	Be		ile, Lasi)					e (i list, ivildale,	waiden Sun	airie)	
should lind Men marker umartic	မ	Unknown 19a. Informant's Name/Relation	anghin (Trea Print)		10h Mailie	ng Address (Street a	Unknown	nal Davida Muselin	- Cit T	- 01-1- 7	- 0-4-1
e, INICITYICIO Z 1 and 2 should be filed Health and Mental Hygi em 27 is marked other ther traumatic event, <u>I</u>			, , , ,					_			
C, IV 1 and Health em 27		Lilly L. Chia 20a. Method of Disposition	- Spouse	20b. Pla		Middlegate		Date Date	20c. Location		
L. Partmen	4	1 Burial 2 Crematic 4 Donation 5 Other 21. Signature of Funeral Serv	(Specify)	State	Linco	sition (Name of matory or other place) In Crematory 2. Name and Addres	y 04/0	09/2008		•	aryland
Departmine Department of the police of the p		Som	ice Licensee			Hines-Rinal	di Funeral	Home, Ind	ver Spri	ing, Ma	ryland 20904
Physician /Medica	_	23a. Part1. Enler the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)		1 4		/)			rest,		Approximate Interval Between Onset and Death
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseque		l infar. intery d	islase			-	years
The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):						
DOX OG path certifica attending ph for use as th	an/Med	IF FEMALE: 23b. Was decedent pregnant		come pf pregnan		Ectopic pregnancy				Date of deliv	*
uires that the dea i signed by the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of dea	ath 5	Other (specify)				Vionth	Day Year
w requires the been signed should be de	þ	Part II. Other significant cond Pulmonai			ting in the u	nderlying cause give	en in Part I.		obacco use co ∕es 2 No		the cause of death? bably 4 Monknow
Of VII. RECORDS, Physician: The law requires trist certificate has been signeral director, page 2 should be considered.	Completed							24a. Was autor perfo 1∐ Yes		b. Were auto prior to co death? 1 ☐ Yes	opsy findings availabl ompletion of cause of 2 No
VICAL T ilclan: Th certificate ector, pag	Be	25. Was case referred to med examiner?	Hasnital: 3				26. Place of Dea	th (Check only o	ne)		
Physl this c	2	1 Yes No			R/Outpatier		4 LI Nursing H	ome 5 Resid		· · · · · · · · · · · · · · · · · · ·	ífy)
dlng Afte	Certification:	Z L / NOOIGOIN	estigation	th, Day Year)	28b. Time o Injury	M 1□	/at <br Yes 2 □ No	28d. Describe I			
tal or Airs after of al Direction by	Certifi		armined 20e. Flace	ng, etc. (Specify)	ne, rarm, su	eet, factory, office		28f. Location (3 City or Tov		mber or Run	al Route Number,
To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	(Check only 2 Medione)		best of my know asis of examinationer stated.	rledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	rred at the time,	date and plac	e, and due t	to the cause(s)
Tot with Con Son Son Son Son Son Son Son Son Son S	Σ	29b. Signature and title of the	Conard			_	e number 28791		29d. Date sign	7, 2	Day, Year)
V		30. Name and address of pers	son who completed caus	e of death (Item)	23a) (Type	Print hilip Dr.	, olney,	M) 20	832		
	tate trar	31. Date filed (Month, Day, Ye APR 0 8	2008 2008	egistrar's Signatu	ure	At a					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

1- Registrar Amend #10c, 4-9-08, per FHDR certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month April 8 Day 2008 Year **Physician** 10:20 AM Gloria A. Daniels-Nalle /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. May 4, 1933 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Mar vland 1 □ M 2 🖫 F 116-32-7848 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼No Director MD Towson -Ellicott City Howard with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 11790 Frederick Road Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23: Iry or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2K No If Yes, Give Year or Dates: Specify. Specify: Black 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Residence Domestic Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) James White Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once. 11790 Frederick Road Ellicott City, MD 21042 James E. Parker II/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory: 04/09/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte- P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (oras a consequence of): **Physician** WEEKS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) certificate has been signed by the errector, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No i □Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64395 APRIL 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST. SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN. MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Exerc

DHMH 17 Rev 1/2001

Registrar

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be executed Box 68760. o ٦ Records, Division or Vital

iled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death.

To the Funeral D rector A

completely filled in by the fu

> State Registrar

Lacey, 31. Date filed (Month, Day, 2008

Lames

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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316 Railroad Avenue, Goldshoro, Maryland

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AS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Registrar AMEND#260er MD4/8/08, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 12:50PM 2008 Barbara Lee Dering 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Renaissance Gardens at Riderwood Village Prince George's Silver Spring 8. Date of Birth (Month, Day, Year) Oct. 19,] If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 📉 F 577-24-6708 84 1923 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Maryland Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 USA 7927 Sandalfoot Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean M. Boardman Rosalie Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7927 Sandalfoot Drive, Potomac, MD 20854 Michael Dering/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ts Burial 2 ☐ Cremation 3 ☐Removal from State April 5, Fort Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Brentwood, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring. MD 20901 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease oronary disease or condition resulting in death) Due to (or as a consequence of): Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pulmonary disease Obstructive Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

traumatic event, the

Health tem 27 item 2

Pages 1 Department of Important: if It any injury or conce. Directo

Funeral

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Completed

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

and burial-tra attending physician the the signed by pe (page 2 certificate this funera To the Hospital or Attending within 24 hours at er death.

To the Funeral Director: After within 24 hours at er death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Physician:

Physician/Medical Completed by Be Certification: To

Examiner

		TE TES 2017 TO SE PTODADIY 4 CONKIOWI
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 ☐ No 2
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🏋 Nursing Home	5 → 5 → Residence 6 □ Other (Specify)
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred	

29c. License number

D59524

29d. Date signed (Month, Day, Year)

2008

April

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State Registrar

LOVEEN J. PUTH UMANA, 3110 GRACEFIELD ROAD, SILVERSPRING, MD 20904 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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and manner stated

luthumana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 2000 DeBruhl Sarah Ann 10 and /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 28,1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1□M 2□F 77 Texas 464-42-3846 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar more of the more once. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Hagerstown Directo Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 131 South Locust Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. þ White 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertram Breazeale Weldon Elizabeth Heywood Walker ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 131 South Locust Street, Hagerstown, Md. 21740 Lloyd H. O'Neil Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory : 04-11-08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Andrew K. Coffman Funeral Home, Inc. 21. Signature of Funeral Service Licensee R. hoes Brudy 40 E. Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) one week Physician /Medical Examiner Securately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed Athnosclu and Division or Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 ☐ Yes 2 No 1□ Yes Hospital or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2 completed cause of death (tem 23a) Type Billing Rd Bonsboro MD 21713.

Registrar

State

32. gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician A M 03 80 0721 WILLIAM DELANEY 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min November 14, 1920 Director 87 Maryland 219-03-9136 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director Frostburg Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 Maryland Avenue U.S.A 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW.II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 h Hygiene. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) supervisor paper mill 12 and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Agnes Watson 2 John Patrick Delaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Maryland wife Frostburg Wilda Delaney 303 Maryland Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State April 07, 2008 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGESTIVE resulting in death) /Medical Due to (or as a consequent of) Examiner MYONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the death certificate be executed Exami that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day signed by the at Id be detached fo 5 Other (specify) 9☐Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2**2**00 2 No 1 ☐ Yes Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2000 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-VA 0x 265 noh 31. Date filed (Month, Day, Year) trar's Signature State APR 0 4 2008 Registrar

	Please	State of Maryland / Dep		_	-	10010
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	edent's Name (First, Middle, Last			2. Date of Death Month	Day Year	3. Time of Death
/Medical	TURA MAE ility Name (If not institution, give	ENNIS	4b. City, Town, or Location of Death	4-15	4c. County of Death	0.401
Examiner 4a. Fac	RORSIDE HEAD	k	BALTIMOR			
Funeral 5. Social Director	al Security Number 6. Se	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Ye.	ar) 9. Birthp Coun	
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of Heal of Heal	ethod of Disposition ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place of Dis	rematory or other place)			
Page Page 141	□Dona#on 5 □ Other (Specify	ARDENT		7-08 H	HOVER,	Mo
Baltim Dermit. Pac Department Important: Once. Dig 7:15	gnature of Juneral Service Licens		 Name and Address of Facility Daughorty Family Funeral H 	Iome And Crematic	on Center, P.A.	
	Part 1. Enter the dise of r comp shock, or heart failure. List only	lication mul caused the death. Do not e	2601 Mountain Road enter the mode of dying, such as cardiac	- Pasadena, MD or respiratory arrest,	. 21122	Approximate Interval Between
Immed	shock, or heart failure. List only plainted the Cause (Final see or condition	COROLO	Algort			Onset and Death
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit cian/Medical Examir	VALE: Vas decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	
ed for sicial	the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
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aw req		1 10-		24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
The tate has page				performer	#? death?	PE No
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Physical direction 10 10 10 10 10 10 10 10 10 10 10 10 10	Yes 2 No	28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 Residence 28d. Describe how		TY)
anding ath. or: After the funding ath.	□ Natural 5 □ Pending □ Accident investigation		M 1 Yes 2 No			
Division of Vital Records, tal or Attanding Physician: The law requires the safter death. al Director: After this certificate has been signed in by the tuneral director, page 2 should be certification: To Be Completed by	☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Certifier 1 Certifying Ph	ysician: To the best of my knowledge, deliner: On the basis of examination and/or	eath occurred at the time, date and place	a, and due to the caus	se(s) and manner as	stated.
Medical	one)	and manner stated.	29c. License number		. Date signed (Month,	
29b. S	Signature and title of certifier		614(492			
30. Na	ame and address of person who	completed cause of death (Item, 23a) (Typ	pe, Print)	1 (*	[10 0	1008 MD 2/20/
Me	jana Dar	ige 821 Nout	h Eutau Shee	t, Ball	image	M/2 2/20
State Registrar	ADD 9 2 711	32. Registrar's Signature	off o	1		

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Registrar DHMH 17 Rev 1/2001

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ORIGINAL

29d. Date signed (Month, Day, Year)

10033280

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENT AVE CUMBERLAND, MD m.D 625 COUPTA

31. Date filed (Month, Day, Year) APR 22

29b. Signature and title of cert

2. Registrar's Signature

and manner stated.

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** April 6, 2008 7:02 Francis Joseph Flynn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomers 2925 Wilton Avenue Silver Spring If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 X M 2 - F 217-44-2414 Director 94 Dec_10, 1913 MA Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, িছ শিক্ষাতে Examilier দেশস্থা হৈ চানাটিত বা 1 ☐ Yes 2 ☐ No Director MD Silver Spring Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or i USA 20910 2925 Wilton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XX No White If Yes Give Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ev 2 James W. Flynn Mary Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9514 Gwyndale Drive, Silver Spring, MD 20910 Peter K. Flynn / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cedar Hill Cemetery Apr 11, 2008 Suitland, MD 22. Name and Address of Facility rancis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) congestive heart failure one year /Medical Due to (or as a consequence of): Examiner mitral regurgitation vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the at d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, Completed by 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the irector, page 2 s autopsy performed? Yes 2X No 1 ☐Yes 2 ☐ No 1 ☐ Yes ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 1 Yes 2 XNo 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 X Natural 1 □Yes 2 □No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10215 Fernwood Rd, Suite 100A, Bethesda, MD 20817 Brent A Berger

and manner stated

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 0 8 2008



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			Registrar Decedent's Name (First, Middle, Last)		061	inicate of D	Calli	2. Date of Dea		1115	3. Time of Death
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	yland how at		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Armed Forces? ☐ Yes 2 X No f Yes, Give ⁄ear or Dates:		Was Decedent of His If Yes, specify Cubar 1 □ Yes 2∏ No	Specify:	Rican, etc.)	Speci	ack, White, <i>ify:</i> WI	, etc. HITE
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ryla	should be nd Menta marked Imatic ev	၉	19a. Informant's Name/Relationship (Type.	Orint)	19h Maili	ng Address (Street a	nd Number or Pu	ral Boute Numbe	er City or Tow	n. State. Zi	in Code)
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	item		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	9)	Date	20c. Location	- City or T	own, State
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Baltimore,	permit. Pages Department of Important: If it any Injury or conce.		21. Signature of Funeral Service Licensee		2:	2 Name and Addres	s of Facility FUNERAL			J L 1110	,
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State of Maryland / Department of Health and Mental Hygiene Peter L. Frenkel 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Year Month 1410 hrs Medical Examiner April 5, 2008 Peter Lewis Frenkel c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville 4108 Canterbury Terrace 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) Germany Director 065-36-1614 63 1X M 2 F 19,1944 Yrs April Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10b. County Yes 2 X No 28a-f show Maryland Montgomery Rockville death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4108 Canterbury Terrace 20853 United States 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funera 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes If Yes, Give Year 1963-1968 Specify: White 1 Yes 2 X No specify: hours after Divorced 2 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than " injury or other traumatic event, the Medical" Baltimore, MD 21215-0036 4 Police Officer Montgomery County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Frenkel Eva Zietz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4108 Canterbury Terrace, Rockville, MD 20853 Joan Ann Frenkel (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven April 9, Silver Spring, MD 2008 4 Donation 5 Other Spacify Cemetery 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Faneral Service Litena 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part I Ent re disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailur Lift hly one cause on each line /Mudical Death a. Contact Gunshot Wound of Torso Imme liate Cause Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ed for use as the burial - tran sician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. ş 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available been prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes 2 No 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Subject shot self FOUND: ___ Natural Division Yes 2 🗸 No 5 Pending Director: d in by the f Apr 5, 2008 1400 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 3 V Suicide Could not be or Town, State) 4108 Canterbury Terrace, Rockville, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 841 April 6, 2008 O.C.M.E. -01 un Oanh 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 31. Date filed (Moeth Day Year) 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

OCME

			State	State of Mary		artment of H		, ,			
	- X()		Registrar 1. Decedent's Name (First, Middle, Last)		007	Tineate of	Death	2. Date of Deat		08	3. Time of Death
ħ.	Physicia		Shirley Frank Garon	n				April 3	, 2008	Year	5:10P. M
	/Medic Examin		4a. Facility Name (If not institution, give s. Renaissance Gardens at		llage	4b. City, Town, o	or Location of Death Spring		4c. County Prin		eorge's
	Funeral Director		5. Social Security Number 007-48-3403 6. Sex	7. Age (In	yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug. 3,1	912	9. Birthp	lace (State or Foreign
	pug M		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	Maryla f sho	ō	Maine York		Ogunqui	t					1 □ Yes 2 No
	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medkal Examiner must be notified at	Funeral Director	10e. Street and Number 111 Meadowlark Lane	e	* (10f. Zip Code 03907		1	Og. Citizen of V United	/hat Coun Sta	try? tes
	death	nera	11. Marital Status	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		e - Americ	
036	urs after al", or ite Exa <u>mine</u>	þ	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	Tricali, etc.)	Specify	k, White, w	hite
2 2	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occup kind of work done	oation during most of word d)	king	16b. Kind of Bu	siness/Inc	dustry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	_	a)		own h	ome	
<u>0</u>	il Hygi other rent, tl	Be Co	17. Father's Name (First, Middle, Last)		200000		18. Mother's Nam	ne (First Middle, I UNK)			
ylar	Menta Menta arked atic ev	To E	Jacob Frank								
, Maryland 21215-0036	and 2 sho ealth and n 27 Is ma		19a. Informant's Name/Relationship (Type Diana G. Weiner -da		19b. Mailir 3118	ng Address (Street Gracefie	and Number or Rulls Road, C	C321 Sil	r, City or Town, ver Spr	state, Zip	Md. 20904
altimore,	Pages 1 nent of H ant; If Iter any or oth		20a. Method of Disposition 1		Ob. Place of Dispo cemetery, cred Sin	matorv or other pla	ery 4/7/		Portlar	,	,
Balt	permit. Departr Importa any inju		21. Signature of Funeral Sarvio License	Thomas		Name and Address Onald V. 400 Powde	Borgward er Mill R	lt Funera load Belt	l Home, sville,	PA Mər	yland20705
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cerebrov	ascular	Accident					Onset and Death
	/Medical Examiner		Todaling in doubly	Due to (or as a cor	nsequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
	cate be executed physician and the bunal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					-			
8760,	be exi		resuming in death) East	Due to (or as a cor	nsequence of):						
687	ficate physics the	edical	d								
Box	death certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pr 1 □ Live birth 2 □		⊒Ectopic pregnanc			23d. Dat	te of delive	ery
o	the deat y the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 ሺ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Mo	nth	Day Year
<u>a</u>	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions con Hypertension; D:		t resulting in the u	nderlying cause giv	ven in Part I.		7.7		he cause of death?
ord	requir een si hould	ted	- tryper tension; b.					1 🗆 Y	es 2 No	3 ☐ Prob	oably 4 □Unknown
Vital Records,	The far ate has page 2	Completed						24a. Was a autops perform	sy g meged? d	prior to cou	psy findings available mpletion of cause of 2 No
Vita	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		. — Tott		th (Check only or			
	Physer this eral dii	. To	1 ☐ Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time o	II SEL DOX	4 KS Nursing H	ome 5 Reside			у)
o	ath. rr: After ie funer	atior	1 ♠ Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury		rk?]Yes 2∐No				
Division or	tal or Attend is after death al Director: , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C		Ilcian: To the best of moner: On the basis of exa and manner stated.							
	Vithir Comp	Me	29b. Signature and title exertification			29c. Licens D24		2	29d. Date signe Ap		Day, Year) 4, 2008
,	10		30. Name and address of person who con Mark Parkhurst,				ilver Spr	ing, Mar	yland 2	20904	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2008	32 Registrar's	Signature	all?					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year April 2008 Dorothy A. Handon 12:50am M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARYLAND HOSPITAL CENTER SOUTHERN CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) 1 □ M **X**(X)F 8/16/1927 245-42-0623 80 Whitakers, NC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2200 31st. Street S.E. 20020 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance U.S. POst Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mae Avent Nicolas Coley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Hamilton / Daughter 2200 31st. Street S.E. Washington, D.C. 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/17/2008 Arlington, VA Arlington Cemetery 21. Signatu of Funeral Service Lie 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe disease or condition resulting in death) Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Due to (or as a consequence of): IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Extanch'as 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsv performed? Yes 2⊠No 1□ Yes

Physician /Medical Examiner

certificate be executed

P.O. Box 68760,

or Vital Records,

Division

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Item 27 is marked other than "natural", or items 23a or other traumatic event, the M-di-al Examiner must be in

Department of Heath and Mental Hy, Important: If Item 27 is marked other any Injury or other transcoore.

3altimore, Maryland 21215-0036

Director

þ

Completed

DC

and physician a as signed by the attending place as the detached for use as certificate

After

Director: /

To the Hospital or Attending Physician: within 24 hours aft

To the Funeral Di

completely filled in Medical Registrar

Examine Physician/Medical Completed by Be ٩ Certification:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

3 ☐ Suicide

2 Accident

4 Homicide

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital:

29c. License number

29d. Date signed (Month, Day, Year)

MD 20735

Piccataway Rd. # 310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIR MOMMAD T. KOLTA. M.).

31. Date filed (Month, Day, Year) 2003 **APR 08**

29b. Signature and title of certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elamin Mohamed Abdelhafiz State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day March 31, 2008 Medical Examiner 1404 hrs MOHAMED 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1219 West Baltimore Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Hours Min. Director 225-75-372 1 XM Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show MD Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes If Yes, Give Yee Yes 2 No specify: Widowed Divorced <u>δ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 'c event, the Medical MD 21215-0036 EMPLOYED of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be MOHAMED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is USMAN (Friend) eesburg 20b, Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State 12008 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardido or respiratory arrest, shock, or he Approximate Interval Physician Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 V No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other₄ examiner? Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 2 No. After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Yes 2 No Director: within 24 hours after death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be determined Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manuer stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 1, 2008 LIWL

31. Date filed (Month, Day Year) State APR 08 Registrar

David Fowler M.D.

32. Registrar's Signatur

111 Penn Street, Baltimore, MD 21201

Chief Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	5	tate of Ivia	iryiano		rtificate of I	Death	-	glerie Reg. No	0000		305	56
6	Physicia		1. Decedent's Name (First,							2. Date of Dea	ath Da	y 2008 ^{Year}	1	Time of Dea 3:45 P	
ls.	/Medic	al .	Walter E. 1 4a. Facility Name (If not ins	Hidalgo	et and number)			4b. City, Town, or	Location of Death	April		County of Dea		3:43 F	141
1	Examin	er I	405 Muddy Br					Gaithers	burg		Мо	ntgomer	У		
1.2	Funeral Director	- 1	5. Social Security Number 087–36–3767	Ж м	2 ☐ F 7. Age		st birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec. 6	v. Year)	CC	thplace ountry) ado:	(State or Fo	reign
	land ow it		Usual Residence of Deced	County		10c. City,	Town or Lo	cation						Inside City Li	
	a-f sh	ctor	MD Mon	tgomery		Gait	hersb	ırg						1 🖎 Yes 2 🗆]No
	or 28	Director	10e. Street and Number	-	1 //10/			10f. Zip Code			10g. Cit JSA	tizen of What Co	ountry?		
	eath w	eral	405 Muddy Br		d #104 Was Decedent 8	ver in U.S	13. \	20878	ispanic Origin? (Sp			14. Race - Ame	erican II	ndian,	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Di	Married	Armed Forces? 1 ☐ Yes 2 █ If Yes, Give Year or Dates:			fYes, specify Cuba 1. MaYes 2. □ No	lispanic Origin? (Sp an, Mexican, Puerto Specify: Ecua	Rican, etc.) adorian		Black, White Specify: La		0	
200	72 hou natura dical E	Completed		ecedent's Educati y highest grade co			16a. Deced	dent's Usual Occup	ation during most of work d)	ing	16b. K	(ind of Business	/Indust	ry	
12	vithin ane.	mple	Elementary/Secondary (College (1-4or 5	+)		oon Clerk			Fin	ancial	Ins	titute	<u>.</u>
d 2	filed v Hygie other 1		17. Father's Name (First, M	Middle, Last)			114111	JOIN OFCER	18. Mother's Name	e (First, Middle,					
lan	Aental Aental rked o	To Be	Braulio Hida	lgo					Praxedes	Araujo					
Maryland 21215-0036	und 2 sho alth and h 27 is ma er trauma		19a. informant's Name/Re Vanessa Hida				405 M	uddy Bran	and Number or Rui ich Road 1	al Route Numb 104 Ga:	er, City ithe	or Town, State, rsburg,	Zip Coi MD	^{de)} 20878	,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ※Crem 4 ☐ Donation 5 ☐ O	nation 3 □Rem	oval from State	20b. Pla ce Che	ace of Dispo emetery, crei	sition (Name of matory or other plac ke Cremat	ory 04/09	Date 9/08		ocation - City or sville,			
Balt	permit. Departr Importa any inje		21. Signature of Funeral S	LHE	litte	MO12	51 B	everly L.	e Crematio Heckroti	te. P.A	. C1				.029
)	Physician /Medical Examiner		23a. Part1. Enter the disease or condition resulting in death) Sequentially list conditions.	Ca. C	hronic Due to (or as	Rena1 a consequ	Fail: ence of):		ng, such as cardiac	or respiratory a	rrest,		Int	proximate lerval Betwee nset and Dea	n th
90,	ficate be executed g physician and s the burial-transit	al Examiner	Sequentially list condition, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as						_				
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ሷ	requires that the de een signed by the a nould be detached i	by	Part II. Other significant of	conditions contril	outing to death b	ut not resu	Iting in the u	nderlying cause giv	ven in Part I.			use contribute			
Division or Vital Records,	e law has b je 2 sl	Completed								24a. Was auto perf 1∐ Yes		prior to	compl	r findings ava letion of caus	ilable e of
ita	(O L)	Be C	25. Was case referred to examiner?	medical	74-30			=	26. Place of Dea						
or V	Physician: r this certific ral director,	2	1 ☐ Yes 2 XNo		pital: 1 ☐ Inpatie 28a. Date of Inju		ER/Outpatie	II JUDON		ome 5 Res		6 □Other (Sp	ecify)		
on (ding P. After fune	tion:		Pending investigation	(Month, Da	y Year)	Injury	Wo	rk?]Yes 2 □ No	200. Describe	now inj	ary occurred			
Division	e Hospital or Attending 24 hours after death. e Funeral Director; Afte letely filled in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of inj building, et	ury - At ho c. <i>(Specif</i> y	me, farm, st	reet, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or F te)	Rural R	oute Numbe	r,
	To the Hospital of within 24 hours at To the Funeral Completely filled in	edical C	29a. Certifier 1 💢 C (Check only 2 🗌 N	Certifying Physic Medical Examine	ian: To the best r: On the basis o and manner st	of examinat	wledge, deal tion and/or in	th occurred at the threath	ime, date and place opinion, death occu	, and due to the	cause(s) and manner and place, and di	as state ue to th	ed. ne cause(s)	
	To the To To To To To To To The Compl	Me	29b. Signature and title of	of certifier	,			29c. Licens	se number		29d. D	ate signed (Mor	nth, Da	y, Year)	
			> M	XUU	WX			D006	2590		Apr	i1 8, 20	800		
(5	() 00 m		30. Name and address of Wendy Wong,						Silver S	prino.	MD 2	20902			
	St	ate	31. Date filed (Month, Da	ay, Year)	32. Reasti	ar's Signa	ture		DIIVCI D	r6;					
	Regist		AP	PR 0 9 20	UB JE	ever	K.	bute							

Amended #5, nls, per fd, 04/08/08, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) n n o

13057

			For State Registrar	,	Cer	tificate of	Death	,	Reg. No	2000	10007
	155	7	Decedent's Name (First, Middle, Last	t)				2. Date of De	eath Da	ay_ Year	3. Time of Death
	Physicia /Medic	_	JOHN HAMILL H	IUTSON				Marc		18 3008	12:04 AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		ath	40	c. County of Death	
676	\$	35-	THE LIONS CEN			CUMBE If Under 1 Year	CRLAND If Under 24 Hr.	C Date of Bir	als.	ALLEGA	
	Funeral Director		- 220- +3-++14-	9X M 2□F 7. Age (In yrs. Ia 89	Yrs.	Months Days	Hours Mir		ay, Ye <i>ar</i>	r) Cou	place (State or Foreign intry) RYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryla f sho	Į.	MD ALLEG	ANY CI	UMBERL	AND					1 □ Yes 2X No
	the 28a-	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cou	intry?
	h with		15103 LAUREL RID	GE ROAD		2150	2			U.S.A.	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. V	Vas Decedent of H	lispanic Origin? (an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Amer Black, White	
5-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1∭Yes 2□No If Yes, Give Year or Dates: WWII		□Yes 2MINo		,		Specify	ITE
ב כ	72 ho 'natur dical	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give I	lent's Usual Occup kind of work done	during most of w	rorking	16b. l	Kind of Business/li	ndustry
7	within iene. than "the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retire	*	SOP	77	S. GOVER	NIMENTI
7	filed w Hygie sther tl		17. Father's Name (First, Middle, Last)	4	COLL	LCITOND		ame (First, Middle			INI ILLIA I
and	d be fintal heed of	Be	LOUIS CASS HUTSO					H CREOLE		•	
≥	should be and Menta marked umatic ev	ျ	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	and Number or i	Rural Route Numb	ber, City	or Town, State, Z	ip Code)
<u>8</u>	nd 2 sho alth and 27 is ma r traum		RUTH HUTSON / WI		10 N	. LIBERT	Y STREE	r, cumbei	RLAN	.D, MD 2	1502
<u>a</u>	1 a Heg the		20a. Method of Disposition	ce	ace of Dispos	sition (Name of natory or other pla	ice)	Date	20c. l	Location - City or	Fown, State
altimore,	it. Pages rtment of l rtant: If its njury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	,	ROCKY GA		01/2008		FLINTSTO	NE, MD
<u>a</u>	permit. Pag Department Important: Is any injury o		21. Signature of Funeral Service Licen	60		. Name and Addre		LIOME 1	D 7\		
n	9 9 2 6 9		Heno 41.	Typcheura	-			L HOME, I ET, CUMB		ND, MD	21502
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	. Do not ente	er the mode of dyi	ng, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Metastati	_	denocu	ranor	na			one year
	/Medical Examiner		resulting in doubly	Due to (or as a consequ	ence of):						•
		ā	Sequentially list conditions,	b. Due to (or as a nonsequ	ence of):						
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
<u>,</u>	exectin and rial-tra	Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
68760	rtificate be executed g physician and as the burial-transit	Medical		∍d							
	rtifica ng ph as th	Med	IF FEMALE:		-						- 38 7 2
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnand Other (specify)	cy			23d. Date of deli Month	lvery Day Year
<u>Р</u>	at the de I by the stached	hy	9 Unknown				uen in Dort I	230 Did	tohanor	n usa contributa te	the cause of death?
Records,	quires tha n signed I ald be det	by	Part II. Other significant conditions of	ontributing to death but not resu	ining in the u	nderlying cause gr	ven in Part i.		Yes	2 De 3□ Pr	
000	aw require s been sig 2 should b	Completed						24a. Wa	s an opsy	24b. Were au	topsy findings available completion of cause of
	sician: The law s certificate has l irector, page 2 s	E O						per 1∐ Yes	formed?	? death? No 1 ☐ Yes	5_A
Vita	lan: ertifica	Be C	25. Was case referred to medical examiner?				26. Place of D	Death (Check only			
	Physic this ce al direc	To	1 Yes 2 No		ER/Outpatier	IL 3 DOA				6 □Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ANatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury) Wo		28d. Describe	e how in	jury occurred	
<u>S</u>	tendi leath. tor: A	cati	2 Accident Investigation 3 Suicide 6 Could not be		mo farm etr		Yes 2 No	29f Location	(Street	and Number or Fi	ural Route Number,
Division or	or All after d Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify	/)	eet, ractory, office	,	City or To			sia, riodio italidoi,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 CertifyIng Ph	nysician: To the best of my know	wledge, deat	h occurred at the	time, date and pla	ace, and due to th	e cause	(s) and manner as	s stated.
	e Hos 124 h e Fui iletely	Medical	(Check only 2 Medical Exar	miner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, death o	ccurred at the time	e, date a	and place, and due	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2-1		29c. Licen	se number			Date signed (Mont	
)	9+		> worrough	Hun MD		D5	5325		Mo	nch 28,	2008 LMD31503
•	,		30. Name and address of person who	completed cause of death (item	23a) (Type,	Print)	1 0 1	5		1	- 200
	nds		Wonsock Shu	5 CM CM CO	5 Bi	i gone	ealsh	Dr.,C	win	perland	(1111)31203
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 3 2008	. Registrar's Signa	Long	de					
			7111 0 0 2001	- CONTRACTOR AND	1						

APR 0 3 2008

Physician /Medical Examiner

physician and s the burial-trans

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certificate has b irector, page 2 sl

After this

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Completed

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Certification: To

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other

Physician

/Medical

Examiner

Funeral

Director

28a-f show

PA

Director

Funeral

Be Completed by

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item 27 is marked other than "natural", or items 23a or 28a-f slother traumatic event, the Medical Examiner must be notified

death with the Maryland

altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

APVII

14,2008

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North Wolfe Street, Baltimore MD 21287-9106 400

Res-000

State Registrar 31. Date filed (Month, Day, Year)

Laura Pourton

6 □ Could not be



DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7/2 Day Year **Physician** 1335 M Sharon Lee HARDEY 2008 la /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 62 184-34-7047 May 13,1945 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 South Walnut Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) production 12 ice cream 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kolich Catherine Yost 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 Is Rose Johnston - sister 18810 Fountain Terrace, Hagerstown, Md. 21742 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/11/08 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 23. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service License 2415 E. Wilson Blvd., Hagerstown, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Lutraparenchy Mil Herourhage
Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): **Box 68760** Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No or Vital Physician: 25. Was case referred to medical examiner?
1 res 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death the Hospital or Attending 1 Natural
2 Accident 5 Pending investigation Fellout of Bed pr-8,3008 1 ☐ Yes 2 ☐ NO 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 ☐ Homicide Musing Hame

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time of the cause(s) and manner as stated. within 24 hours a To the Funeral C Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

19,001

25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-1062

orchard terrace Bd.

AM.11, 2008

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		, ,	iene eg. No.	0 13000
P	10	-4	1. Decedent's Name (First, Midd	fle, Last)				2. Date of Deat	h Nov.	3. Time of Death
- 60	Physicia /Medic		RUBY	POWELL	INGHAM			APRIL 6	, 2008 Year	12:57P M
	Examin		4a. Facility Name (If not institution FREDERICK MEM	_	AL	4b. City, Town, c	r Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
4	Director	8	385-36-4841 Usual Residence of Decedent	1□M 2X F	71 Yrs.	Months Bays	Tiodio Nilli	April 16	5,1936 Ke	ntucky
	ryland how	,	10a. State 10b. County		10c. City, Town or Lo	_				10d. Inside City Limits
	e Ma ta-f s	Director	Maryland Free	derick	Frede	rick				1 □Yes 2X No
	ith th or 28 se no	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
	ath w	ra I	8512 C, Yello			2170				tates
336	within 72 hours after death with the Maryland ene. than "natural", or tems 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗓 No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9	2 hou	ted	15. Decede	nt's Education est grade completed)		dent's Usual Occup	oation during most of working	20	16b. Kind of Business	/Industry
Maryland 21215-0036	d within 72 hogiene. It than "natu	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	ique Deal	d)	ng .	Retail Sa	les
land	should be filed vind Mental Hygies marked other tumatic event, the	To Be (17. Father's Name (<i>First, Middle</i> James H	e, Last) Ienry			18. Mother's Name	(First, Middle, M		
ary	2 shou and M is mar	-	19a. Informant's Name/Relation	ship (Type. Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Number	; City or Town, State,	Zip Code)
	and 2 alth a 27 is		Rayna Farmer /	Daughter	851	2 C, Yell	ow Springs	s Rd./ H	rederick,	MD 21702
ore	of Health of Health if item 27 i	ı	20a. Method of Disposition	2 [] D (t	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce) D	ate	20c. Location - City of	Town, State
Ĕ	it. Pages rtment of I rtant: If ite njury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Stauffer			/2008	Frederick,	MD.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Funeral Home, 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betting and Address of Facility 21. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 26. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facilit							
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V	Physician	ì	Imme an e Cause (Final disease or condition	_a met	astatio	brea	A CA			Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	truc	1'~			
	xamme,	_	Sequentially list conditions,	b. bow	a consequence of).	11000	NON			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence ory.					
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
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.O. Box	The law requires that the death certificate be e. te has been signed by the attending physician tage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant condit	tions contributing to death t	out not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tol	1/	to the cause of death? Probably 4 □Unknown
Vital Records,	ne law req has beer je 2 shou	Completed						24a. Was a autops	y prior to	autopsy findings available completion of cause of
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	sician: certific rector,	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1X Inpati	0.000	- action Oth	26. Place of Death			
on or	Attending Physician: r death. ector: After this certific. by the funeral director,	ion: To	27. Manner of Death 12 Natural 5 Pendi	28a. Date of Inj (Month, Da	ury 28b. Time of	of 28c. Inju	4 LI Nursing Hor		ence 6 □Other (Sp ow injury occurred	ecify)
Division or	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could	minod 200. Place of In	ury - At home, farm, st c. <i>(Specify)</i>			28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce		ing Physician: To the best al Examiner: On the basis of and manner s	of examination and/or i					
	o the	Mec	29b. Signature and title of certifi		attu.	29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
	F ≯ F ŏ		1 mm	Hee NO		20	03510			6/2008
	7		30. Name and address of person	n who completed cause of	death (Item 23a) (Type				/	,

State Registrar

DHMH 17 Rev 1/2001

21701

APR 0 8 2008

31. Date filed (Month, Day, Year)

Myung Nam / 400 West 7th St./ Frederick, Maryland

32. Registras Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 2008 Leonard R. Jenkins April 1, 11:05 am^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George's Clinton Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral №** М 2 Б Director Washington, D.C 85 1/24/1923 577-28-7990 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show ed at 10d. Inside City Limits r 28a-f sh notifled XIXIYes 2 No Director Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 9211 Stewart Lane 20735 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ⊠ Yes 2 □ If Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 Is marked other tha any in]ury or other traumatic event, the N Teacher New York College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Wainwright Gelesby Jenkins Mary Lillian Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wainwright Jenkins Jr./ Nephew 11405 Kettering Terr. Upper Marlboro, Md. 20774
lace of Disposition (Name of Disposition (Nam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/14/2008 Landover, Md. Harmony Memorial 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATherosclerot /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2☒ No page 2 s funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 ⊠ Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1170/ 11-ingstan nd #10/ fot carbytan MO20786 sidanoal 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

045765

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JEREMY **Physician** HOPE JURIANSZ 830 PM APRIL 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1**∑** M 2□ F 44 Dec 10, 1963 Director 217-11-7933 Sri Lanka Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a, State 10b. County 1 ☐ Yes 2X No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14204 Greenspan Lane 20853 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status "natural", or Item: edical Examiner n Black, White, etc. 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: Indian ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Packaging Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental James H. Juriansz Patricia M. Schokman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trauonce. Sorbello /Sister Eleanor 11331 Palatine Drive, Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) Cate of Heaven Cemetery Apr 9, 2008 Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 43 yrs EISENMENGERS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): 68760, attending physician Physician/Medical the as Box IF FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Vital 0 Division

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31. Date filed (Month, Day, Year)

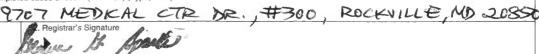
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(Check only one)

29b. Signature and itle of

APR 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

00061083

29d. Date signed (Month, Day, Year)

APRIL 5,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** " 45 AM 2008 Kruhm ohn /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death 4c Examiner Haven Nursing Home torest Itimore 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Davs Hours Min. 212-68-1822 47 Director January 9, 1961 District of Columbia Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be p 301 Olney Sandy Spring Road 20860 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2
If Yes, Give
Year or Dates: 2X No Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: δ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician NIH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked oth Be ဂ Charles Henry Kruhm, Sr. Betty Lou Bergmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Connie Somerville - Sister 6621 Haviland Mill Road, Clarksville, Maryland Item 27 other t 21029 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 = 5 1 Surial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 04/07/2008 Burtonsville, Maryland Union Cemetery 21. Signature of Funeral S vice Licen ee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 Tuns 23a. cart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the ! attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy pertorme 2 No 2 No Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 14 Natural 5 | Pending 4 hours after death. -uneral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hin 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number D37573 2008

Registrar
DHMH 17 Rev 1/2001

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30. Name and address of person who com

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31. Date filed (Month, Day, Year)

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eted cause of death (Item 23a) (Type, Print)

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82. Registrar's Signature

Main

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 Year Month 04 Day **Physician** 1. 46 AM O /Medical 4ą. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mari Comery WAY HUCH MUELTR YKuma V Nex 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July8,1938 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Months Days Hours Min Washington, DC 577-52-6842 69 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County "natural", or Items 23a or 28a-f show edical Exaπiner must be notified at 1 Xes 2 No Maryland Prince George's College Park Director 10f. Zip Code 20740 10g. Citizen of What Country?
United States Oe. Street and Number 5025 Ontario Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or tter 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. Specify. þ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) private Printer 17. Father's Name (First, Middle, Last) Henry Keane 18. Mother's Name (First, Middle, Maiden Surname) Be Bernice Botts 19b. Mailing Address (Street and Number or Ryral Route Number. City or Town, State, Zip Code) 5025 Ontario Road College Park, Maryland 20740 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health al Important: If item 27 Is any Injury or other trau Ethel M. Keane -wife 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 4/5/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MAKRUCIEVAL CARDINASCULA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 40 I or Attending Physician; after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 2 10 2 R/Outpatient 2 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manney Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation M 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mar 27, 2008 1040 Kerns Bevis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany County Nursing Home Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Oct 29, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F K/M 220-10-4832 Director 89 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Modical Examiner must be notified at Cumberland MD Allegany Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 229 Baltimore Avenue Apt 405 items 23e Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other than "neturel", or iter 1 Yes 2 No KYes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 2 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Columbia Un. College 12 laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Candace (Eaton) Kerns David W. Kerns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 st Department of Health and Important: if item 27 ia n any injury or other traun once. PA 15501 798 Brubaker Street Somerset Linda Staub step-daug 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 3/31/2008 Cumberland MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or corpolitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician PNEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner JEUROGENIC Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transit ALZEIMZRS nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death signed by the atter 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2€ No 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 0 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural death 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0-14865 2008 trans 3 Name and address of person who co leted cause of death (Item 23a) (Type, Print) JR. STANO m.D. man. Hosp. MED BLDG

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiano		rtificate of			entai Hy	gien Reg. N	/ 11	08	13067	
٠.	1. Decedent's Name (First, Middle, Last) Physician Eva Kiss									2. Date of Do Month		ay 2008	Year	3. Time of Death 2:30 A M	
Y - 3	/Medical Examiner 4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death					c. County	of Death	2.30 A	
	b Examina	- '	5500 Friendship Blvd. Chevy Chase								N	lontge	omery	7	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last)							If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, Di 07/11/	Birth 9. Birthplace (State or Ford Country)				
	Director		215-38-4754	1□M 2⊠F	94	Yrs.	World Buy	libuio		07/11/	191	3	Hung		
21215-0036	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation						1	0d. Inside City Limits	
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	the N	Director	10e. Street and Number 10f. Zip Code								10a. C	Citizen of What Country?			
	with 3a or t be	۵	5500 Friendship	Blvd.	20815							ted States			
	ns 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	3. 13.			spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)			14. Race - American Indian,			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2X N If Yes, Give Year or Dates:	No 1 ☐ Yes 25 No Specify:					erto Rićan, etc.) Black, White, etc. Specify: White					
	72 ho	ted	15. Decedent's I	Education	16a. Decedent's Usual Occupation (Give kind of work done during most o					of working			b. Kind of Business/Industry		
7	ithin he.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done during most of working OO NOT use retired)				1.6.14				
e, Marylar	led w lygier her th	ပိ	17. Father's Name (First, Middle, Las	Pharmacist				aria Niama	/Finns seintalt		edical				
	I be fi	Be	Ivan Horvath					Szoke	dle, Maiden Surname)						
	hould mark matic	은	19a. Informant's Name/Relationship	(Type Print)		19h Mailir	ng Address (Stree				her City	or Town	State Zin	Code)	
	nd 2 suith ar 27 is r trau		Edith K. Lauer /			1	Shaker				-				
	s 1 al f Hea ltem othe	. 1	20a. Method of Disposition	_	20b. Pl	ace of Dispo	sition (Name of matory or other pla	ace)	D	ate	20c.	Location -	City or To	own, State	
	Page nent c nt; If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		National Crematory							Falls Church, VA			
a	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Lice	ensee	e la		2. Name and Addr								
מ	B a a b b	7 1	5130 Wisconsin Ave. NW Washington, DC 20016												
k.			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician		Immediate Cause (Final disease or condition	a. Cerebro	vascu	ılar A	ccident							Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		and the same of th										
	execu n and iat-tra	Еха	that initiated events resulting in death) Last C Due to (or as a consequence of):												
	tificate be executed g physician and as the burial-transit	edical	d												
			IE EEMALE.												
C. Box	attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth							23d. Date of delivery Month				
	the at	sici	in the past 12 months? 1									Month Day Year			
7.	hat the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions								use contr	ibute to th	ne cause of death?		
ecords,	w requires that the death cer been signed by the attendin should be detached for use	d by	TV- OTW								**	pably 4 □Unknown			
	> 0 %	Completed	24a. Was an autopsy performed?							24b. Were autopsy findings available					
ĕ	has has	dmo								auto	autopsy prior to completion of cause of performed? death?				
n or vital	Physician: r this certifica ral director, p	ပ္ပ									1 Yes 2 No 1 Yes 2 No				
		0	examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \)	ER/Outpatier	26. Place of Death (Check or tient 3 DOA Other:					Residence 6 Other (Specify)					
		Ë	27. Manner of Death	28b. Time o	of 28c. Injury at 28d. Descrit					be how injury occurred					
	Attending r death. ector: After by the fune	atio	14 Natural 5 Pending 2 Accident investigation	M 1 Yes 2 No											
Š	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	eet, factory, office					(Street and Number or Rural Route Number, own, State)						
2															
		Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	o the	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mont								i (Month,	Day, Year)			
T G b A D													pril 7,2008		
7	10		30. Name and address of person wh	o completed cause of d	eath (Item	23a) (Type.	Print)								
			Loreto Albiol ME					thesda	a, MD	20814					
	Sta		31. Date filed (Month, Day, Year) APR 0 8 2	32 Registra		ture	acti)								
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State of Maryland / Department of Health and Mental Hygien 🖟 🦳 🗎 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4-5-2008 Year Physician Lutfu Kalafatci 10:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5105 Crossfield Ct. #12 Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 3-10-1932 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F 101-54-5694 Bulgaria 76 Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural, or items 23s or 28s-f show the Mudical Exempler must be nutified at Md. Montgomery Rockville 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5105 Crossfield Ct. #12 20852 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural; or item ery injury or other traumatic event, the Mudical Exercited pince. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Clothing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ahmet Kalafatci Lutfiyk Kalafatci 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17820 Falcon crust Cir., Germantown, Md. 20874 Kate Decker- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Md. Parklawn Cemet. 4-6-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 411 Kennedy St, N.W. Universal Mortuary, Wash, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IS Month Immediate Cause (Final disease or condition resulting in death) Cancer Gastric months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit To the Hospitei or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Inpatient examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04-6-08 20542 30. Nam and addr ss of person who completed cause of death (Item 23a) (Type, Print) .110 Irving St, N.W., Wash, D.C. 20010 _at 20 S--bett M.S 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	e or ivial ylariu		ificate of			monte	a riygic		g. No.	200	8 1306	
Physicia	ın/	Decedent's Name (First, Middle,Last)								Month Day Year			3. Time of Death	
edical Exami			Leggon						Ap	oril 2, 200	08		0315 hrs	
		4a. Facility Name (if not institution, 6557 Pennsylvania Ave	,		1	4b. City, T Fores		ocation of I	Death			ounty of Death		
Funeral				e (In yrs. las	st birthday)		r 1 Year	If Under 2	24Hrs. 8.	Date of Birtl			hplace (State or	
Director		,	X M 2 F	o (iii y. o. ioc	21 Yrs	Months	_	Hours	Min			Foreig	n	
'n		Usual Residence of Decedent										10d. Inside City Limits		
Maryland 28a-f show any <u>d at once,</u>		1 XYes 2									1 XYes 2 No			
arylan 8a-f si	Director	Md . 10e. Street and Number	P.G.	l	opper	10f. Zip		.0		10	g. Citizen	of What Cour	ntry?	
th the Maryland 23a or 28a-f sho notified at once.		4520 Lords L	anding Ro	ad #	512	2	0772	2			Unit	ted St	ates	
MD 21215-0036 2 should be flied within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Man	12. Was Decedent	Ever in U.S	. 13. Wa	s Decede	nt of Hispa	anic Origin	? (Specify Puerto Rica	Yes or No-	14.	. Race - Amer White, etc.	can Indian, Black,	
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X						No specific					o ale	
urs aft tural'	ģ	15. Decedent's Education (Specif	16a. Deceder	nt's Usual	Occupatio	n (Give kir								
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21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	ompleted	11				Coo						Privat	e	
filed il Hyg	ပ	17. Father's Name (First, Middle, L	,				18		,	st, Middle, N		rname)		
212 uld be Menta mark	To B	Clifton Pet 19a. Informant's Name/Relationshi	erson (Type, Print)		19b. Mailin	g Address	(Street	Lisa and Numb	er or Rural	eggon Route Num	ber. City	or Town, State	, Zip Code)	
MD id 2 sho alth and m 27 is aumati		Robert Leggor			452 Upp lace of Dispos	0 Lo	rds	Land	ding	Road	7 # 5	12		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natura or other traumatic event, the Medical Examin		20a. Method of Disposition 1 X Burial 2 Cremation		20b. P	lace of Disport	sition (Nar	ne of cem	etery,	Da	te	20c. Loc	cation - City or	Town, State	
Pages nent of ant: If		4 Donation 5 Other Spe	-	عاد ا	.elawn			ry	4/9/	8 0	Lone	g Isla	and, NY	
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		gnature of Funeral Service Licensee) 22. Name and Address of Facility Hodges & Edwards F.H.												
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Physician 'Medical	4	failure. List only one cause o	each line.						uido oi 103	piratory arre	ost, sirook	, or ricart	Between Onset and Death	
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wour			SO And F	Right Ai	-						
		Sequentially list conditions,	b											
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uted nd ransit														
760, frate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED											
760 Teate b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregn								Date of deliver		
Box 687 The death certifice the attending properties the for use as the forms of t	Physician/	past 12 months?	1 Live birth 4 Pregnant a	t time of dea	=	etal death other (Spe		Ectopic	pregnancy		l M	lonth	Day Year	
Boy e death the att	hysi	1 Yes 2 No 9 Unkn	own g Unknown	10-22-22-2		W. (-)		- 222	205					
P.O.	by P											the cause of death?		
IS, P.C. quires that en signed I	pe									24a. Was			utopsy findings available	
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of Vi ing Physi After this uneral dir	٤	1 ✓ Yes 2 No 27. Manner of Death	1 Inpati		ER/Outpatien 28b. Time of			y at Work?	Nursing Ho	d. Describe		ce 6 Othe	er: Scene	
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed rs after death. al Director: After this certificate has been signed by the attending physician and led in by the funcral director, page 2 should be detached for use as the burial - transi	Certification:	1 Natural 5 Pendi	Apr 2, 2008	Year)	0000 hrs	,,		es 2 🗸 I	lsut	bject was				
ivisi or Att after de Direct	tifica	3 Suicide 6 Could not be							100	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Divi Hospital or 24 hours afte Funeral Dir tely filled in	1	1.298 Centiler												
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: x completely filled in by the fi	Medical	Test: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									he cause(s)			
F \$ F 5	ž	29b. Signature and title of certifier		29c. License number					29d. Date signed			onth, Day, Year)		
		Famele Youthard, ms O.C.M.E. April 2, 20							2, 2008					
20. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
S Regis	ate		32. Registra	ar's Signatu	The R.	,				•	-			
Regis	ueli	MIN U O COO												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** RONALD HARRY LINZ 1:05 P APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING HOME BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. MARYLAND 212-40-6728 65 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 K Yes 2 □ No Director MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 12616 SELSEY ROAD 21842 IIS Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No WHITE Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED CONTRACTOR PAINTING Department of Health and Mental Hyg Important; If item 27 is marked other any Injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THELMA CLAIR RODEKURT HARRY GEORGE LINZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK F. LINZ/ BROTHER 37701 RIVER RUN, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 DRemoval from State MELSONS CREMATORY 4-7-08 4 □ Donation 5 □ Other (Specify) FRANKFORD, DELAWARE 21. Signature of Funeral Service Mel'son funeration services, Ltd. 43 Thatcher St, Frankford, Delaware. 19945 23a. Part1. Enter the disease of shock, or heart failure. comp ications that caused the death. only one cause on each line. Do not enter Onset and Death Immediate Cause (Final disease or condition resulting in death) Damentra Lewy **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 1 ☐ Yes 2∏ № 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attend nours after death, neral Director; / y filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Coastel Halway Farmet Island, De 199944)illedan 31. Date filed (Month, Day, Year) 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:45 PM 3008 Harry J. Lease, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Lions Care Center Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 □ F 215-20-5397 82 October 27, 1925 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits crtant; If item 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 Meshach Frost Village 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: WW ∏ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. bobbin department 10 textile manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental **Edna Donald** Harry Lease, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Fages 1 and 2 Department of Health a Important: If item 27 is any njury or other trau 21532wife Maryland Frostburg Helen Lease 72 Meshach Frost Village 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State April 02, 2008 Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** CONGESTIVE 2 years. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ELEN/HY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-tran Due to (or as a consequence of) Box 68760, attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend after death filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

nes

State

2+

Bishop

Walsh Rd. Cumberland MD 21500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 01, 2008 APRIL 1332 MABRY CHARLIE JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1**X** M 2 □ F Pitt County, NC 64 244-68-6991 2/21/1944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo **Bladensburg** Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20710 United States 5999 Emerson Street # 802 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Sears 10 should be filed wind Mental Hygies snould be filt. Ith and Mental Hv. 7 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be the Health and M Mary Smith James H. Mabry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1, ent of Hea Richard Mabry / Brother 2101 Sunnybrook Rd. Greenville, N.C. 27834 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Injury or permit. Page Department of Important; If any Injury or 4 Donation 5 Dother (Specify) 4/7/2008 Ayden, N.C. Ayden Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. M01085 5538 Marlboro pike Forestville, Maryland 20747 Jur (s Part1. Inter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I ist only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed was an autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1∐ Yes 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA L_O this Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation (Month, Day Year) Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital or within 24 hours af

To the Funeral D

completely filled in 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1, Day 2008 ar **Physician** April 1 Mary Lee Mortfeld 9:55PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 12222 Valerie Lane Laurel If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland If Under 1 Year 8. Date of Birth (Month, Day, May 7, Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □ F 214-22-2003 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hyglene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Marical Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince George's Laurel Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12222 Valerie Lane 20708 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 ΪNo Specify: White ģ Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0.12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) Milton Robert Iglehart 18. Mother's Name (First, Middle, Maiden Surname)
Mary Susan Baldwin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Brenda L. Cherba -daughter 12222 Valerie Lane Laurel, Maryland 20708 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H int; if ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4/5/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Banara Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Small Cell Lung Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) been signed by the a 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer; COPD 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 s autopsy performed? 1 ☐ Yes 2 🖸 No 2 🔀 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 🔼 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760,

of Vital Records,

Division

Saltimore, Maryland 21215-0036

6 ☐ Could not be 3 T Suicide 4 Homicide

29a. Certifier (Check only one) 29b. Signature and title of certifier

and manner stated. D43346

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) April 2, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address f person who completed cause of death (Item 23a) (Type, Print)
Rita Gupta, M.D. 7525 Greenway Center Drive, #215 Greenbelt, Maryland 20770

Registrar

Medical

31. Date filed (Month, Day, Year) 2008





To the Hospital within 24 hours a To the Funeral Completely filled in the Funeral Completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day p M Marie Louise McCook 2008 9:30 April 3, 4a. Facility Name (If not institution, give street and number) 4h. City Town, or Location of Death 4c. County of Death Greater Laurel Health & Rehab. Laurel Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours Min. 1 □ M 2 🖾 F 132-01-5809 87 May 2, 1920 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3603 Everton Street 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1943-46 1 ☐ Yes 2 ♣No Specify. 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Dow Jones Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Alexander Carman <u>Marie Louise Hansen</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Joanne Henderson/Daughter 3712 Oak Avenue, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 2Flancisof Collins Funeral Home Inc. indrew? 500 University Blvd., W., Silver Spring, MD20901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urinary Bladder Cancer, Squamous Cell Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, Im *Im after Impr. The must be notified at any injury or other traumetic event, Im *Im after Impr.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The lew requires that the death certificate be executed physician and s the burial-tran ettending p for use as t signed by the e page 2 s

Division of Vital Records, P.O. Box 68760,

24 hours after deat Funeral Director:

Certification: To Be Completed by Physician/Medical	-1	ш
To Be Completed		ian/Medical
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filled in by completely

1 □Yes 2 □No 9 □ Unknown		9 Unknown	death 5 ☐ Othe	er (spec	ify)		_			
Part II. Other significent condition	s con	tributing to death but not res	sulting in the underly	ing cau	se given in Part I.	23e. D	id tobacco u	use contribute t	o the cause	of death?
Sepsis						. 1	□Yes 2	□No 3□P	robably 4	Unknown
							utopsy erformed?	prior to death?	completion	ngs available of cause of
25. Was case referred to medical examiner?					26. Place of De	ath (Check on	ly one)			
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27. Manner of Death 1 ⅓ ⅓atural 5 ☐ Pending 2 ☐ Accident investiga	tion	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M		. Injury at Work? 1 ☐ Yes 2 ☐ No		8d. Describe how injury occurred			
3 Suicide 6 Could no 4 Homicide determin		28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fa	ctory, o	ffice	28f. Locatio City or	n (Street an Town, State	d Number or R	ural Route i	Number,
29a. Certifier (Check only one) 1 ☑ CertifyIng 2 ☐ Medical E	Phys	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, death occu ation and/or investig	irred at ation, ir	the time, date and place may opinion, death occ	ce, and due to curred at the tir	the cause(s) ne, date and) and manner a d place, and due	s stated. e to the cau	se(s)
29b. Signature and title of certifier	_		_	29c. l	icense number		29d. Dat	te signed (Moni	th, Day, Yea	ar)
· ONHAA	2	MD			D53411		Apr	cil 4,	2008	

State Registrar Jagdish Shesadri, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane, #210, Bowie, MD 20715 3 Registrar's Signature

within 24

08-02520 Andrew T. Miller

Ме

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 3075

		1-For State Registrar				Cei	rtificat	e of	Death					Reg. No).).	0	0 1001
Physicia dical Exami	ın/	1. Decedent's Nam And	•	le,Last)	Thom	as			Mill	er			Date of De Month March 30	eath Day	Year		3. Time of Death 1846 hrs
		4a. Facility Name (_	nd number)		4t	c. City, Tov		ocation of			4	4c. County o	Death	
Funeral Director		5. Social Security 1	Number	6. Sex		ge (In yrs. I 14	last birthd	lay) Yrs.	If Under Months	1 Year Days	If Under	r 24Hrs. Min.	8. Date of B	Birth(MN	W/DD/YYYY)	Foreign	nplace (State or Maryland Intry)
, ,		Usual Residence o		1		Lia aii					1						40.41-34-03-13-34
land f show an	ō	10a. State PA		Bedford		10c. City	, Town or		dford								10d. Inside City Limits 1 Yes 2 X No
the Mary a or 28a- tified at	Director	10e. Street and Nu		rdon Roa	ad				10f. Zip C	ode	155	22		10g. C	itizen of Wh	at Coun USA	try?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any rother tranmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Marri 3 Widowed		larried Arm			J.S. 1	If Ye	s, specify	Cuban, I	Mexican,		cify Yes or I	N 0-	White	, etc.	an Indian, Black, Thite
ours after	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Busin																
3036 within 72 ho er than "ns Medical Ex	Specify:																
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be C	17. Father's Name John		Fran		M	Mille				Jo	оу		Lyn		Е	Burket
MD 2 12 should th and M 127 is m umatic e	10	John F.				her									City or Town		
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Baltin permit. P Departme Importan injury or		21 Signature of Ft	Other Suneral Service		m			22. Na	ame and A	ddress o	of Facility	Adam	ns Fan	nily	•	ral	Home, P.A. 21502
Physician /Medical		23a. Part I. Enter to failure. List or			hat cause	d the death	h. Do not	enter the	e mode of	dying, s	uch as ca	ardiac or r	espiratory a	arrest, s	shock, or hea	ırt	Approximate Interval Between Onset and
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P.O.	by P	Part II. Other sign	ificant condi	tions contribu	ting to dea	th but not i	resulting i	in the ur	n derl ying c	ause giv	ven in Pa	rt I.					the cause of death?
Records, The law require ficate has been si page 2 should t	Completed													topsy	F	rior to c	topsy findings available completion of cause of
Vital Recorysician: The law in this certificate has the director, page 2 sh		25. Was case refe								Diagram	of Dooth	(Ob a al. a a	1 ✓ Ye	rformed s 2		leath?	es 2 No
Vital lysician this cert directo	o Be	examiner?	2 No	Hospital: 1	Inpati	ent 2 🗸	ER/Out	patient		10	Other 4	(Check or Nursing	Home 5	Resi	idence 6	Other	r:
Division of Vital Records, P.O. Box 6i Inspiral or Attending Physician: The law requires that the death cert 24 hours after death. Funcral Director: After this certificate has been signed by the attendir tely filled in by the funeral director, page 2 should be detached for use a	ation: T	27. Manner of Dea 1 Natural 2 Accident	5 Per	iding FO	Date of In Month, Day, UND: r 30, 200	Year)	28b. Til FOUN 1745 I		ijury 28		at Work es 2 ✔	ln.			injury occurr n vehicle		irned
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Division To the Hospital or Attence within 24 hours after death To the Funcral Director:	29a. Certiffer (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certiffer (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
	Σ	29b. Signature and	title of certifi	1	~ 1D ·					License O.C.N	number				d. Date sign larch 31,		nth, Day,Year)
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	ate	31. Date filed (Mor	nth, Day, Year,	la.	32. Registr	ar's Signat											
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 8 2008

32 egistrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1 - State Registrar			Maryland						910110		
				Cer	rtificate	of Deat	h		Reg. No.	008	1307
Decedent's Name			1 1 !					2. Date of De	eath Day	Year	3. Time of Death
Lorraine	e Elizab	oeth Monta	.Ld1					april	05	2008	1158
~ ^	13 ()	give street and number	1 -		4b. City, To	own, or Locatio	n of Death			ounty of Death	
Meme		1050 itel		NOTE	-	STON			TI	ALBOT	
5. Social Security Nu 146-38-039	99	. Sex	Age (In yrs. la	st birthday) Yrs.	If Under 1 Months	Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Bi (Month, Di 07/30/		Cou	place (State or Forei Intry) Jersey
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
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MD 10e. Street and Num	Montgor	mery	Bet	hesda	1,00						
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17. Father's Name (First, Middle, La	st)	I			18. Mot	her's Nam	e (First, Middle	, Maiden Su	ırname)	
Frank Haw	rylo					l l		ckiewic		-	
19a. Informant's Na	me/Relationship	(Type. Print)		19b. Mailin	g Address (S	Street and Num	ber or Rui	al Route Numb	er, City or T	own, State 7i	o Code)
Maurice M	iontaldi	/ Husband	d					Betheso			,
20a. Method of Dispo		, nassan	20b. Pla	ce of Dispos	sition (Name	of		Date		tion - City or T	own, State
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disease or condition resulting in death) Sequentially list con if any, leading to im- cause. Enter University of the	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
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iniel Nutase		1- For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment o rtificate o			Menta	ıl Hygi		eg. No.	200	8 1307
Physicia edical Exami			First, Middle,Last)			37 .					Date of Dea	Day	Year	3. Time of Death 0706 hrs
R. 1		Daniel 4a. Facility Name (if n	not institution, give	street and nur		Nutase	4b. City, T	own, or Lo	ocation of I		pril 2, 20		County of Deat	
		12135 Turnsto						Spring					lontgomery	
Funeral Director		5. Social Security Nur 219–11–85		M 2 F	7. Age (In yrs. I 52		Month rs.	s Days	If Under 2 Hours	Min	Date of Bir. APR 0	,	Forei	rthplace (State or gn Duntry) Nigeria
		Usual Residence of D	7			T								Land desire Charling
ow an			Ob. County Montgome	76.17		Town or Loc ver Sp								10d. Inside City Limits 1 Yes 2 No
aryland Sa-f sh	Director	10e. Street and Numb	-	ТУ	311	ver sp	10f. Zip	Code			[1	0g. Citiz	zen of What Cou	
the Ma a or 2 tiffed	Dire	12135 Tur	nstone C	ourt			2	0904				Uı	nited S	ates
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral										rican Indian, Black,			
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urs aft tural" amine	d by	15. Decedent's Educ		or Dates:		16a. Deced	ent's Usual	Occupatio	n (Give kir			_	Specify: ${ m B1}_{ m a}$ (ind of Business	
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within spiene.	omp	17. Father's Name (Fi	irot Middle Leet)	4		Accou	ntant				an rst, Middle,		ne World	l Bank
Baltimore, MD 21215-0036 Depruit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Filed and Menhal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	Victor	irst, Middle, Last)		Nutase			ı	JNAVA	•		Margen	Surname)	
21, nould the ord Men is mar	To I	19a. Informant's Name		pe, Print)		19b. Maili	ng Address					mber, Ci	ty or Town, Stat	e, Zip Code)
, ME ind 2 sl salth ar em 27 rauma		Mary Jane 20a. Method of Dispos		/neic		1300 Place of Disp					ltsvi		, Maryla Location - City o	and 20705
IOFE		1 X Burial 2	Cremation 3	Removal fro	m State	crematory or	other place)			_				
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Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and		
⊏xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):											Death	
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	iner	if any leading to imm cause. Enter Underly	ying Cause	Due to (or es a	consequence o	rt):								
اق ۾ ل	xan	(Disease or injury that events resulting in de		Due to (or as a	consequence o	of):								
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Box 6876 death certifical he attending ph of for use as the	ian/	23b. Was decedent pro past 12 months?	egnant in the	1 Live bi	rth ant at time of de	ath -	etal death	3	Ectopic p	regnancy	,	ł	Month	Day Year
tal Records, P.O. Box 68760, cian: The law requires that the death certificate by certificate has been signed by the attending physic ector, page 2 should be detached for use as the bur	Physician/N	1 Yes 2 No	9 Unknown	9 Unkno		5 (Other (Spe	cify)						
P.O.		Part II. Other signific		contributing to	death but not r	esulting in the	underlying	cause giv	en in Part	i.				the cause of death?
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COFC law re has be e 2 sho	nple										auto			completion of cause of
Vital Recysician: The his certificate director, page		25. Was case referred	d to medical					26 Place o	of Death (C	heck only	1 Yes	2N	0 1 🗸 \	es 2 No
Division of Vital Records, the Hospital or Attending Physician: The law required the Puneral Brector: After this certificate has been simpletely filled in by the fumeral director, page 2 should be	o Be	examiner?	H	ospital: 1 ir	npatient 2	ER/Outpatie			thor:	Nursing H		Reside	ence 6 🗸 Othe	er: Scene
fing Ph After t funeral	\vdash	27. Manner of Death		28a. Date ((Month,	of Injury Day,Year)	28b. Time o	f Injury		at Work?	- 1	d. Describe	how inju	ury occurred	
Sion Vitend death cror:	atio	1 Natural 2 Accident	5 Pending Investigatio	n		L			es 2 N	_				
Division pital or Attene ours after death teral Director:	Certification:	Garaide	6 Could not b	e	of Injury - At h	ome, farm, sti	eet, factory	, office bu	ilding, etc.	28	f. Location (or Town,		ind Number or R	ural Route Number, City
Hospit 24 hour Funer: tely fill		4 Homicide 29a. Certifier (Check only) 1 Ce	ertifying Physicia		of my knowled	ge, death occ	urred at the	time, date	e and place	e, and du	e to the cau	se(s) an	d manner as sta	ited.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 M	ledical Examiner:	On the basis o and manner st	f examination a ated.	and/or investig	ation, in my	opinion,	death occu	irred at th	e time, date			
	Σ	29b. Signature and titl	le of certifier				290	. License					Date signed (M	onth, Day, Year)
3		Card.	K HOL	lla	of death (the	2321		O.C.M	.⊏.			Apri	il 3, 2008	
		30. Name and address Carol Allan, M		ompleted caus nt Medical E		111 Penr	Street, I	Baltimo	re, MD 2	21201				
St Regist	ate trar	31. Date filed Month	Day, Year) 2008	32. Re	gistrar's Signat	ure does	to.							
				-		4								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Doris Mae Nichols 0325 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death CITIZENS Social Security Number HAVRE DE GRACE HARLORI NURSING Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 1 ☐ M 2 🕱 F 220-05-8935 85 Maryland Sept. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Concove Way 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Bennington Anna Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Nichols. Jr. (Son) 21 Stacey Ct. Berlin. MD 21811 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemeteru 4/15/2008 Havre de Grace. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ohndructions () Immediate Cause (Final our disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery nt pregnant 3 ☐ Ectopic pregnancy 2 months? Month Year Day 5 Other (specify) significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gaster inter In 1 Nes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-. any injury or other traumatic events.

/Medical

Director

Funeral

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Completed

Be

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Examiner he law requires that the death certificate be executed

Completed by Physician/Medical

Be

P

Certification:

Medical

Michols Johns Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

within 24 hours a To the Funeral I

IF FEMALE:
23b. Was decede
in the past 1
1 ☐ Yes 2
9 ☐ Unknow

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

24a. Was an 1□ Yes 26 Place of Death (Check only

24b. Were autopsy findings available

opsy formed? 2 √ No	d	rior to death? □Yes	etion] No	of c	aus
one)					

				20. 1 lade of Dea	in (Oncor only one)	
lc	ospital: 1 □ Inpatient 2 □	ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how in	ury occurred

M 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and the of certifier 29c. License number

D-15994

4-11-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Letica 5 Ga (V22 M.D. 625 S. WWON AVE HAUNE DE GRACE M.D. 5, Ga/vez 625 MD. 21078 2. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 2 2

	For State Registrar		-		artment of F rtificate of I			Reg. No.	3008	1308
n	1. Decedent's Name (First, Middle, La Elouise Peterson	ŕ					2. Date of De Month March	Day	Year 008	3. Time of Death
al er	4a. Facility Name (If not institution, gi		mber)		4b. City, Town, or	Location of Death	march		ounty of Death	12.1Jan
	3365 Southern Ave		,						nce Geo	maala
	Social Security Number 6.	Sex 1□M 2⊠TF	7. Age (In yrs. I	a <i>st birthd</i> ay) Yrs.	Suitland If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di 11/8/1	th ay, Yea <i>r)</i>	9. Birth	place (State or Foreid
	Usual Residence of Decedent						11/0/1	710		
_	10a. State 10b. County		10c. City	y, Town or Lo	ocation				1	10d. Inside City Limit
Director	Maryland Prince (George's	Suit	1and	10/ 7: 0 1			Table Same		ty⊡Yes 2⊡N
					10f. Zip Code				en of What Cour	
Funeral	3365 Southern Ave		edent Ever in U.S	S. 13.	20748 Was Decedent of H	ispanic Origin? (Sc			d State Race - Americ	
	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes	2 € No		If Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)		Black, White,	etc.
9	3 HWidowed 4 □ Divorced	If Yes, Gir Year or D		,	1⊡Yes 2y⊋No	Specify:		S	Specify:Blac	k
Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind	d of Business/In	dustry
	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retired	1)	9			
	17. Father's Name (First, Middle, Las	<i>t</i>)		Licen	ised Pract	ical Nur 18. Mother's Nam			vate	
Re	Peter Samuel Jone							, waiden o	umame)	
<u> </u>	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	Simsie		ner City or	Town State Zin	n Code)
	· ·									
Ì	Gloria Peterson (20a. Method of Disposition	reen/Si	sterLaw 20b. P	lace of Dispo	Temple Hi osition (Name of matory or other place	LLL Rd T	emple H Date	ills, 20c. Loca	$-\mathrm{Md}$ -20 ation - City or To	748 own, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from	State	emetery, crea	matory or other plac National	4/4/2			el, Mar	
1	21. Signature of Funeral Service Lice		1141		2. Name and Addre	ss of FacilityPone	Funera	_Laure	nes P	yrand M
	Fortha. A	anos b	101085	5.	538 Marlb	oro Pike	Forest	ville.	. Md. 20	7747
	23a. P rt Enter the disc se, or cor shock, or heart failure. List only	npli alions that c	aused the death							Approximate Interval Between
	Immediate Cause (Final disease or condition		REATIC C							Onset and Death
	resulting in death)	- u.	(or as a consequ		OIM					
d)	Sequentially list conditions.	b								
١	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):						
xamin	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	¢								
al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	¢	(or as a consequ							
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g	if any, leading to immediate cause. Entre Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequitome of pregna birth 2 □ Fetal nant at time of d	ncy	□ Ectopic pregnanc □ Other (specify) _	у		23		
Pnysician/Medical	if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (23c. If yes, out 1	(or as a consequence of pregnation to come of pregnation and at time of discovery	ncy death 3[eath 5]	Other (specify)	,	23e. Did		Month	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat Month Dav Ethel Lee Price 12:34pm April 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6306 Riggs Road Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 1 □ M 2 🖼 F 246-24-9411 Bennettsville, 9/27/1922 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1√∏Yes 2 No Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6306 Riggs Road 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Entreprenuer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Beard Mary Dimery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14506 Delcastle Drive Mitchellville, Md. 20721 Deborah Price- Scott/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 4/9/2008 Suitland, Maryland Lincoln Memoria1 22. Name and Address of Facility Pope Funeral Homes, P.A. MO(0) 538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dylng, such as cardiac or respiratory arrest, Immediate Cause (Final LONGE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

/Medical requires that the death certificate be executed

Physician Examiner

burial-tran

esn

for

attending physician the as

the

þ signed b

certificate has been

page 2

funeral director

After this

death.

within 24 hours after death To the Funeral Director: filled in by the

completely

2

Certification:

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

Hospital

/Medical

Director

Funeral

Completed by

Be ပ

Physician/Medical Examiner Completed by Be

IF FEMALE: 23b. Was decedent pregnant in the past 12 mon 9 Unknown

25. Was case referre examiner?	
27. Manner of Death	
≯ ☐ Natura!	5 Pending

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? Injury

28d. Describe how injury occurred 1 TYes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

106 Irving St. N.W. Suite 3200n Washington, D.C.

29b. Signature and

29c. License number

29d. Date/signed (Month, Day, Year) 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Watkins MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature APR 0 8 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / State Registrar		tificate of L		ientai Hy	giene Reg. No	200	18	13082	
×	Physicia		1. Decedent's Name (First, Middle, Last) Helen Elizabeth Pesce				2. Date of De	eath	008 Ye		3. Time of Death 7:10P. M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or Laurel	Location of Death	1		. County of D		George's	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last. 206–12–8326 1 \(\triangle M \) \(\frac{1}{2}	birthday)_	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av Year)			ace (State or Foreign try) Vania	
21	Director		Usual Residence of Decedent				June6,	1925	Pe	nns	ÿlvəniə	
	e Marylan ta-f show	ctor	Maryland Prince George's Laure	_	ation					10	0d. Inside City Limits 1 XYes 2 □ No	
	th with th 23a or 28 ust be no	Funeral Director	7312 Summerwind Circle		10f. Zip Code 20707				tizen of What ted St			
036	ould be filed within 72 hours after death with the Maryland Merkla Hygiene. arked other than "natural", or Items 23a or 28a-f show arked other, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes □ No If Yes, Give Year or Dates:	1	/as Decedent of Hi Yes, specify Cuba □ Yes 2【XNo	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit				
Maryland 21215-0036	vithin 72 h ne. han "natu •• Medical	Completed	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	(Give ki life. Di	ent's Usual Occupa ind of work done of O NOT use retired Prate Sec	during most of work l)	ing		ind of Busine king	ess/Ind	ustry	
ל פר	e filed v al Hygie other t vent, th	Be Co	17. Father's Name (First, Middle, Last)	COLPO	Tate Sec	18. Mother's Name		, Maider	Surname)			
rylai	2 should b and Menta Is marked aumatic e	To	Joseph McCracken VanNorman 19a. Informant's Name/Relationship (Type. Print) 1	19h Mailine	Address (Street	Gladys Nand Number or Rura			<u>-</u>	la Zin	Cadol	
	es 1 and 2 should to f Health and Ment I Item 27 Is marked r other traumatic		JoLynne Pesce -daughter 7.	'312 S	ummerwin	d Circle	Laurel	, Ma	ryland	20)707 	
Baltimore,	Pages 1 ment of H ant: If Ites lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place ceme Gate	of H		metery 4/		Sil		rir	ng,Maryland	
Ball	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Licensee Danald V. Brywarth	Do 44	name and Address nald V. 00 Powde	Borgwardt r Mill Ro	Funera ad Bel	al H tsvi	ome, P 11e, M	A lary	land 20705	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Do not enter	r the mode of dyin	g, such as cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death	
1	/Medical Examiner		disease or condition resulting in death) POSSIDIE MYOCAPCIAI IIIIAFCLIOII Due to (or as a consequence of):									
	7. 2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Renal Failur		а					+		
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
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	certifica Iding ph		IF FEMALE: 23c. If yes, outcome pf pregnancy	,					23d. Date of	deline		
O. Box	requires that the death cert een signed by the attendin nould be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 3□E	Ectopic pregnancy Other (specify)				Month		Day Year	
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Vita	Physiclan; r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/	(Outpotion)	3 DOA Othe	26. Place of Death						
n O	iding Phys h. After this funeral dir	H		Bb. Time of Injury	28c. Injun Work	4 Li Nursing Ho	me 5 L Resi 28d, Describe			Specify)	
DIVISION	teat tor the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	, farm, stre		Yes 2□No	28f. Location (City or To	Street ai wn, Stat	nd Number o e)	r Rural	l Route Number,	
	To the Hospital or Ai within 24 hours after of To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) 1	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and time of Condition		29c. License	e number 4874			ite signed (M			
1	9		30 Name and address of person who completed cause of death (Item 23s Shahab Z. Bavani, M.D. 7300 Van D	la) (Type, P			rland o	-				
	Sta	te	24 Date (Had (Measter Day Vers) 200 Demistrario Cignaturo			rei, Mary	19110 Z	0/0/				
	Registr	ar	APR 0 7 2008	500								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Formend#2 Per PHY. State of Maryla 1- Registrar 4/8/08 AACO HFALIH DEPT. CMH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of DeathApril 4, 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NELIGH PARKS 04 2008 08:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 10/02/1928 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1M∏M 2□F **Funeral** 79 Yrs 214-20-7481 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 TYes 2 No Directo Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 238 Edgewater Drive 21037 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Şq White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Manager Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Griffith F. Parks Gladys Mister is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trau Angelyn W. Parks/Wife 238 Edgewater Drive, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/09/2008 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fynery Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home permit. any ir 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a onsequence of); Examiner 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate has 1□ Yes 2□ No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 TI DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 4 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 Yes 2 No neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital within 24 hours a

To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check onl) one and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature title of 29c. License number who completed cause of death (Item 23a) (Type, Print) ON Och trs 31. Date filed (Month, Day, Year) State APR 0 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 02, 2008 9:50 P Jacqueline Peeler Apr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 156 Oak Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 💢 F 76 237-42-7674 Feb. 07, 1932 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at Pasadena 1 ☐ Yes 2√2 No Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 156 Oak Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Home** Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Lego ပ Spencer Greer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 156 Oak Drive Pasadena, MD 21122 Rev. Christopher Peeler/ son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial 20c. Location - City or Town, State 20a. Method of Disposition April 08, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2008 Park 21. Signature of 22. Name and Address of Facility P.A. Severna Park Funeral Home 495 Cov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death cartificate be executed burial-transit and Due to (or as a consequence of): Box 68760, ettending physician Physician/Medical us as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months2 1 ☐ Yes 2 ☐ Ho 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobagco use contribute to the cause of death? Division or Vital Records, Be Completed by funeral director, page 2 should be 1 es 3 Probably 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 0 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 10 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manny of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide Letertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended#8perFH FCHD, KS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 Year April 3, Ralph Malcolm Pickett 11:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mount Airy Mount Airy Carrol1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-07-9462 16, **Director** 91 Nov. Maryland Usual Residence of Decedent 1916 16. 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 Midway Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator General Store permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Cleveland Pickett Elva Margaret Kellev ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25404 19a. Informant's Name/Relationship (Type. Print) Bette Vaughan, daughter 4541 Greensburg Road, Martinsburg, West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/9/2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar Spring Methodist Cemetery Poplar Springs, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature o Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or leart failure. List only one cause of each line.

Immediate C. (Final disease or condition resulting in death)

a. BLADDER CANCINOMA Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BUSTATE 1 Yes 2 No 3 Probably 4 Unknown CANCEN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Maturai 5 Pending To the nosposal within 24 hours after death.

To the Funeral Director: After the function of t investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records,

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

Ronald E. Miller,

31. Date filed (Month, Day, APR 0 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2008

32. Registra Signature

Registrar DHMH 17 Rev 1/2001 #4 Culwell Avenue,

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

126499

Mount Airy, Maryland

29d. Date signed (Month, Day, Year)

April 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Mar State of Mar Registrar	yland / Depa <i>Cei</i>	artment of F rtificate of a			ene 200	8 3086
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary Caryl Perantoni				2. Date of Death April 4		3. Time of Death 12:05 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospi	+ a 1	4b. City, Town, o	r Location of Death	IIPI III	4c. County of De	eath
* Tiles	Funeral	9/8/	5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgor (02r) 9. E	Birthplace (State or Foreign
	Director		213-42-8419 1□ M 2점F Usual Residence of Decedent	64 Yrs.	Months Days	Hours Min.	Jan 28,	1944 Pe	country) nnsylvania
	aryland show	'n		Oc. City, Town or Lo		e			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	h the M r 28a-f r notifie	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What	
	sath wit s 23a c nust be	eral D	9435 Gentle Circle 11 Marital Status 12. Was Decedent Ev	ovia II C 10 1	20886			United St	tates
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		was Decedent of H f Yes, specify Cuba 1 □ Yes 23 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
21215-0036	72 hou "natura dicai E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation during most of worki	ing 16	6b. Kind of Busines	
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ğ	0 = 0 %	Be	17. Father's Name (First, Middle, Last) Ermine Perantoni			18. Mother's Name	(First, Middle, Ma		
Maryland	should be fand Mental Be marked of sumatic even	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number, (City or Town, State	e, Zip Code)
e, N	1 and 2 Health and 27 ls		Chrissie Wilcox (Daughter) 20a. Method of Disposition	2700 20b. Place of Dispo		ew Lane,		s, MD 214	
altimore,	Pages nent of I int: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropoli Cremat	natory or other plac	^(e) Apri 200	1 4,	•	a, Virginia
Balti	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic evonce.		21. Signature of Euneral Servicy Licensee	22	. Name and Addres	ss of Facility De	Vol Fune	ral Home	, MD 20877
F	Physician /Medical			ne death. Do not ente	er the mode of dyin	ig, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death One Day
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.	tonsequenne of):					
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2	ital or / rs after ral Dire	Certii	4 Homicide determined building, etc. ((Specify)			City or Town,	State)	Tara Fronto Hambor,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of reaching the desired from the basis of examiner: On the basis of examiner state.	xamination and/or inv	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner e and place, and o	as stated. lue to the cause(s)
}	withi Com	Ň	29b. Signature and title of certifier **Diexander Mula	mle	29c. Licenso	e number 65819		1. Date signed (Mo	
	ψ		30. Name and address of person who completed cause of deal Alexander Mulamula, M.D., 99			Drive. R	ockville.	MD 2085	50
	Sta Registr		31. Date filed (Month, Day, Year) 3 Registrar's					,	-

			For	State of Marylar				lental Hygi	ene			
_			State Registrar		Cei	rtificate of	Death		g. No.	008	10	087
	Physicia	ın	Decedent's Name (First, Middle, La Violet		Dulo			2. Date of Death		າດຊັ ^{ear}	3. Time.d	40 M
, z	/Medic		4a. Facility Name (If not institution, give	Irene	Pyle	4b. City. Town. o	r Location of Death	III KED		nty of Death	14.	40
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	f sho	ř	WV Mine	eral	Rid	geley					1 ∐Yes	2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen o	of What Cou	ntry?	
	filed within 72 hours after death with the Manyland Hygiene. Ither than "natural", or items 23a or 28a-f show with the Medical Extminer must be notified at		Rt. 1 Box 195				26753			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		lace - Ameri lack, White,		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2□Mo	Specify:		Spe	cify:	hite	
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Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe	Ì	21. Signature of Funeral Service Lice		22	2. Name and Addre	effir Funeral Ho	ome, PA			-	
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			23a. Party. Enter the disease, or cor shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approxima Interval Be Onset and	ite etween
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Division or	or Attend after death Director: /	icat	ccident investigation 3 ☐ Suicide 6 ☐ Could not		nome, farm, st]Yes 2□No	28f. Location (Si	treet and Ni	ımber or Bu	ral Route Nu	mher
2	after after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	ify)	, , , , , , , , , , , , , , , , , , , ,		City or Town	n, State)	mbor or rid	, a, r , toute , 14	mbor,
	Hospital of the Hospital of Funeral C			hysiclan: To the best of my kr								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 ☐ Medical Exa	miner: On the basis of examination and manner stated.	nation and/or if	nvestigation, in my	opinion, death occu	irred at the time, o	late and pla	ce, and due	to the cause	·(s)
	To t To t	Ž	29b. Signature and title of certifier		0	29c. Licens	se number	2	9d. Date si	jned (Month	n, Day, Year)	
)			Mobistran	/ - 00000	X M	·/	D14865		ARRI	L 15	Lt, 20	208
			30. Name and address of person who	/ '			VENUE CI	ITTE 001	OTDAT	א דרוקו	ח אי	21502
	Sta	te	BARRERA, ROBUST 31. Date filed (Month, Day, Year)	IANO J., M.D.,		LMUKLAL A	VENUE, SU	TIE ZOI,	, CUME	LKLAN	υ, MD	21502
	Registi		APR 2 2 208	8	San	120						

DHMH 17 Rev 1/2001

ORIGINAL

Reg. No. 2008

3. Time of Death

	Dhysisi		Decedent's Name		,						2. Date of D Month	eath Da	v v	'ear	3. Time of	Death
	Physici Medie		Carltor	n Micha	el Phi	llips					April		, 200		4:28	\mathbf{P}^{M}
	Examir		4a. Facility Name (If r	not institution, give	street and num	ber)		4b. City, To	wn, or Locat	ion of Death	1	4c.	. County of	Death		
			Greater	Baltimo	ore Medi	cal Cer	nter	Tows	on				Balti	more	2	
	Funeral		5. Social Security Nur	mber 6. S	ex	7. Age (In yrs.	last birthday) If Under 1 \ Months D	/ear If Ur	nder 24 Hrs. urs Min.	8. Date of B	irth	9	Birthpl Count	ace (State of	Foreign
	Director		215-90-2	2255 1	M M 2□F	44	Yrs.	Months	ays 1100	IVIIII.	Sept.	12,19	963		ÿland	
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	arylaı show d at	-		10b. County			y, Town or l							10	od. Inside Cit 1 ☐ Yes	
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7K 2	s afte	γF	1 X Never Married 3 Widowed 4		1 X Yes If Yes, Give Year or Da	2 □ No		1 ☐ Yes 2 🛚	No Spe	cify:			Specify:	Whi	te	
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$\mathcal{L}_{\mathcal{H}_{i}}$ Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🔀	Cremation 3 🛭	Removal from S	State C	remat rect	ematory or othe	r piace)	Apri	1 18, 8	Yo	rk.	РΆ	17401	
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Box	nding use	M/N	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outc	ome pf pregna							23d. Date	of delive	ry	
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	the iin 2 the the	Medical	one)		and mann	er stated.										,
	Note that	2	29b. Signature and til	tle of certifier	Clar	udle	~ M	D 29c. Li	cense numb		0	29d. Da	te signed (Month, l	Day, Year)	08
			,									71				
-			30. Name and address	ss of person who	completed cause	of death (Item	23a) (Type	Print	FRLE	S 27	REET	, B	ALT	11	ORE	
]	1-17 1121 12								MD	21	204			

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** XED MOHAMMED 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adventist Hospital Rockville Monta Trove If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2□F 66 Director INDIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f show Examiner must be notified at MD Director Monta 1 Yes 2 □ No GlermanTown omery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 17013 Indian Grass Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural' traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Microbiologist Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Abdula 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any Injury or other tra once. Qadri Health (Son Nasser Indian Grass Dr. Germanlown MD20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 88 National Members 4 21. Signature of Funeral Service Licensee 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Immediate Cause (Final 40 days Physician neumoni disease or condition resulting in death) /Medical Examiner 4ear Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed respirator Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? for Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen aldomina 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2▼No has page 2 autopsv perform certificate Division or Vital 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending thin 24 hours arter oct the Funeral Director; Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year) APR 0 8 2008

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19529 Doctors
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ylarue DD 03 31 ZOON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4nnapoli led cal Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F Director NONE 31,2000 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. Çity, Town or Location 10a. State 10b. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ∑Yes 2 □ No rince Director GILLY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10 SA 0 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MI) 20 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATIONAL CEMETERY 4/5/2008 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician N /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 menths?
1 Yes 2 XNo
9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9□Unknown s been signed by a should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has page 2 After this certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Nnpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Vatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. death. 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C To the Hospital 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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hashery/ 31. Date filed (Month, Day, Year) APR 08

Medical Leslie 2001 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Risia, MD

State

Registrar

313112008

nnapolis , Md 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) A Month 2. Date of Death 3. Time of Death 474 2003 **Physician** 655 Elnora ,27 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner General Hosp (ounty lumbla Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Maryland 219-12-5245 87 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedir al Examiner must be notified at MD Howard Columbia 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane #323B 21044 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Drug Store Saleslady 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Lorraine Stiffler Leroy Walter Truckenmiller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5470 Wild Lilac Columbia, MD 21045 Kenneth L. Shuck/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 04/05/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Ser vice License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO125 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aoren **Physician** hea disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to for as a consequence of): Division or Vital Records, P.O. Box 68760, wer Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 28e. Place ot injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1K CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 50370 30, Name and address of person who completed cause of death ((tem 23a) (Type, Print) clarksulle MD lane signal Juzan 4 Bdo 5005 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 9 2008

			For State Registrar		Stat	e of Ma	aryland	d / De	eparti C <i>ertif</i>	ment <i>ficate</i>	of H	ealth a	and N	/lenta		giene Reg. No	Espet Co	108	# +CS++0788*#	3092
	Physici		1. Decedent's Name	_	Last) Reid									Mo	te of De	ath Da	av	Year		of Death
)	/Medic Examin		4a. Facility Name (I	f not institution,	give street an	,			4t	o. City, T	own, or	Location	of Death			40	. County		٥.	
-	Funeral		30917 Ra 5. Social Security N	lumber	.11 Roa 6. Sex 1□ M % C	7. Age	e (In yrs. I	V	day) If	ordo Under 1 Ionths		If Under Hours	24 Hrs. Min.	(M	te of Bir	th y, Year	albo	9. Birthp Coun	try)	e or Foreign
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	ne Maryla 8a-f sho ptified at	ector	MD	Talbot			Cord												1 □ Y	es 2 XNo
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Nur 30917 Ra		11 Road	d			- 1	10f. Zip (2162						USA		Vhat Coun	try?	
330	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed		ed 1 If Ye	Decedent I ed Forces? Yes 2 X N es, Give r or Dates:		S.		Decede es, specif Yes 2		ispanic Ori in, Mexical Specify:		pecify You Rican,	es or No etc.)			e - Americ k, White,	etc.	
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and 41	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r raumatic event, <u>the Med</u>	Be	17. Father's Name James Ed		,			Fact	ory	Wor	ker	18. Mothe		,			1try n Surnam	Farm	Fac	tory
Maryia	t 2 should h and Mer 7 is marke raumatic	T ₀	19a. Informant's Na	ame/Relationsh	ip (Type. Prin	t)						and Numb	er or Ru	ral Rou	e Numb			State, Zip	Code)	
nore, i	ages 1 and of Healt it if item 2:		Edna Wil 20a. Method of Disp	position Cremation	3 □Removal	from State	C	lace of E	Disposition cremate	on (Name ory or oth	e of her plac	l Roa		Date		20c. L	ocation -	City or To		
Dallimore	permit. P Departme Importani any Injury once.		21. Signature of Fu	5 Other (Spuneral Service L		10			GO 11	ame and	Addres OME	ss of Facili	ătic	n S	ervi	.ce	P.0	• Box	784	
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L,	cuted nd transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	5	с	ue to (or as														
8/00,	certificate be executed ding physician and ise as the burial-transit	dical Ex	resulting in death) I	Last	d	ue to (or as	a consequ	uence of):											
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coras, r	requires that the een signed by the rould be detache	by	Part II. Other signi	ficant conditio	ns contributing	g to death b	ut not resu	ulting in t	he unde	rlying ca	use give	en in Part	l.	2				ribute to th		of death? Unknown
ě T		Completed													4a. Was auto perfo ☐ Yes	psy rmed?		prior to cou death?		gs available of cause of
N I I	Physiclan: The law r this certificate has t ral director, page 2 s	o Be C	25. Was case refer examiner? 1 ☐ Yes 2X		Hospital:	1 Inpatie	unt 2	ER/O	nation*	3 🗆 🗠	Othe	26. Place		th (Che	ck only o	ne)				
on or	Phy rthig rald	ification: To	27. Manner of Deat 1 X Natural 2 \sum Accident		9	Date of Inju (Month, Da	ry	28b. Ti	me of ury		c. Injur Work	4 LI NI					6 ∐Oth ury occuri	er (Specit red	Y)	
VISION	Attending ar death. After by the fune	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ot be 28e.	Place of inju	ury - At ho	ome, farr						28f. Lo	cation (Street a	and Numb	er or Rura	I Route N	lumber,

Cer Medical

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title D0053815

29d. Date signed (Month, Day, Year) April 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORAH M- VULIMOD 9/2D Market Stuet Went MP 2/629

31. Date filed (Month, Day, Year)

32. Persistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

(1) as

			F	lease T	ype or Prir	nt in Bla	ck In	delible Ink	. Ensu	re All C	Copies	Are l	egible.	
			For		State of Ma	aryland /					ntal Hyg	jiene		
			1 - State Registrar				Cei	rtificate of	Death			leg. No.	2008	13093
	Physici	an	Decedent's Name (First,)	D					Date of Dea Month	Day	Year	3. Time of Death
100	/Medic		Rayn 4a. Facility Name (If not ins		street and number)	Rei	use	4b. City, Town, o	or Location	of Death	04	09	08 County of Death	│ 0322 M
	Examir	ier	WMHS Bra					Cumber					Allegan	
	Funeral		5. Social Security Number	6. Se		e (In yrs. last		If Under 1 Year Months Days		Min.	Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
2	Director		176-10-8760 Usual Residence of Decede		JWI ZUF	90	Yrs.			SE	PT. 4	,191	7 PENN	SÝLVANIA
	/land ow at		10a. State 10b. C			10c. City, To	own or Lo	ocation						10d. Inside City Limits
	a-f sh	cto	MD 2	LLEGA	NY	FRO	STBU	RG						1 ☐ Yes 2 ☐ No
	or 28 be no	Dire	10e. Street and Number					10f. Zip Code			1	_	en of What Cou	intry?
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notifiled at	Funeral Director	48 TARN TERI		12 Was Decedent	Everin II S	12	2153		isin? (Specific	. Von or No		S.A. 4. Race - Ameri	ican Indian
10	r item	Fun	11. Marital Status1 □ Never Married 2 □	Married	12. Was Decedent : Armed Forces? 1X Yes 2 □ N	No		Was Decedent of I If Yes, specify Cub			an, etc.)	'	Black, White	
5-0036	ral", o	þ	3 XWidowed 4 ☐ Div	orced	If Yes, Give Year or Dates:	WWII		1 ☐ Yes 2 🔀 No	Specify:				Specify: WH	ITE
2-0	72 hc "natu dicai	Completed	15. De (Specify only	cedent's Edu highest grad	cation e completed)	11	6a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of working			id of Business/I	ndustry VTIC AND
2121	within lene. than " he Med	d m	Elementary/Secondary (0	-12)	College (1-4or 5	i+)		RSONNEL						A COMPANY
d 2	r Hygi other ent, tl	Be Co	17. Father's Name (First, M	iddle, Last)						er's Name (Fi	irst, Middle,	Maiden S	Surname)	
/lan	uld be Mental rrked ric ev	To B	HENRY REUSE						SA	RA CLA	RK			
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, <u>the Medical</u>	ľ	19a. Informant's Name/Rel					ng Address (Stree						11.
	1 and 1 Health em 27 i		JUDITH WORKT	ÆISTE	R / DAUGH			3 MAGRUD	ER ST	REET,				21502
Baltimore,	Pages 1 an nent of Hea nt: If item		1 X Burial 2 □ Crem			ceme	etery, cre	matory or other pla		04/12/2			cation - City or T	
ij			4 ☐ Donation 5 ☐ Ot 21. Signature of Funeral Se			ALIO		PARK 2. Name and Addr	ess of Facili	itv			TOONA,	PA
ñ	permit. Departr Importa any inju		Ukond	/ G),	Tepohe	uch		UPCHURC 202 GRE					VID. MD	21502
			23a. Part1. Enter the di shock, or heart failure	se, or compl List only or	icatio that caused ne cause on each lin	the death. D	o not en							Approximate Interval Between
- 82	Physician		Immediate Cause (Final disease or condition		Ath	erosc	len	otre Ca	ndio	VUSCU	lar	Dis	ease	Onset and Death 2 VPWS
	/Medical Examiner		resulting in death)		Due to (or as	a consequen	ce of):							
6		e.	Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		o. — Due to (or as	a bonsaqueni	ce of,.							-
	cuted	Examiner	that initiated events		D									
50,	certificate be executed ding physician and se as the burial-transit		resulting in death) Last		Due to (or as	a consequen	ce of):							
6876	cate b	dica			d									
9 X	leath certificate be attending physici I for use as the bu	Physician/Medical	IF FEMALE:		23c. If yes, outcome	pf pregnancy							2d Data of deli	
Box	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	iciar	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No	TIL T	1 □Live birth 4□Pregnant at	2 ☐ Fetal de	ath 3[⊒Ectopic pregnand ⊒Other <i>(specify)</i> _	су				3d. Date of delive Month	Day Year
P.0	at the by the tache	hys	9 ☐ Unknown		9□ Unknown									
	ires that the de signed by the a be detached f	by F	Part II. Other significant co	onditions co	ntributing to death b	ut not resultin	g in the u	nderlying cause gi	ven in Part	1.				the cause of death?
oro	w requir been si should b	sted									1 U Y	es 2[No 3∐ Pro	obably 4 Unknown
Vital Records,	has by	Completed				 	- :-				24a. Was a autop perfor	sy		topsy findings available ompletion of cause of
B	iclan; Th certificate ector, pag		25. Was case referred to m	adical							1□ Yes	2 No	1 ☐ Yes	27 No
	Physiclan; r this certificaral director, I	To Be	examiner?	⊢	Hospital: 1 ☐ Inpatie	ent 2 XER/	Outpatier	nt 3 DOA Ot	la a s	e of Death (C			□Other (Spec	364)
n or	ding Phys n. After this funeral dir		27. Manner of Death	londing	28a. Date of Inju	ry 28	b. Time o				. Describe h			any)
Siol	Attending it death. ector: After by the fune	atio	2 ☐ Accident ☐	Pending nvestigation Could not be				M 1	Yes 2	No				
Division	or Att	Certification:		letermined	28e. Place of injude	ury - At home c. (Specify)	, farm, sti	reet, factory, office		28f.	Location (S City or Tow	itreet and n, State)	d Number or Ru	ral Route Number,
_	spital ours a neral		29a. Certifier	rtifylng Phy	sician: To the best	of my knowled	dge, deat	th occurred at the t	time, date a	nd place, and	I due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only Me one)	dical Exami	iner: On the basis o and manner sta	f examination	and/or in	nvestigation, in my	opinion, de	ath occurred	at the time,	date and	place, and due	to the cause(s)
	To the To the comp	Me	29b. Signature and title of	2 -	0			29c. Licen	se number	-		29d. Date	e signed (Month	n, Day, Year)
	5+		Monse	sk st	in 1	MD		n	00 5	5325		A	pril C	9,2008
	VI 21		30. Name and address of p		ompleted cause of d	eath (Item 23	a) (Type,	Print)	1,18	CHN	000			, Day, Year) 09, 2008 MD21502
	カルム Sta	ate	31. Date filed (Month, Day,	- 0.	32. 2 gistr	ar's Signature	> 0	1->FIUT	WAL	->1/ /	11 (ino	en avnet	11/21502
	Regist		APR	1 0 200	18	w St	4	perte						
DHI	MH 17 Rev 1/2	001					1							

Division or Vital Records, P.O. Box 68760, after death Hospital within 24 hours To the Funeral

6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier auroi

29c. License number

29d. Date signed (Month, Day, Year)

D 0061382 April 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14816 Physicians Lane, #152, Rockville, MD 20850 Shama R. Mittal, M.D.,

31. Date filed (Month, Day, Year) State

APR 0 8 2008

Registrar

Medical

			Clair of Mariland (D		-	•	
			State of Maryland / Dep			0000	10005
			Registrar	ertificate of Death		No. 2 U U U	13033
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		GEORGIANA REDMAN			3 2008	2015 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	M		WMHS - BRADDOCK CAMPUS	CUMBERLAND if Under 1 Year If Under 24 Hrs.	O Date of Birth	ALLEGAN	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birti	nplace (State or Foreign untry)
le:	Director		219-34-6427 1 1 72 Yrs. Usual Residence of Decedent		4/14/35) W	IV
	land ow <u>t</u>		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary f sh	ō	WV Mineral 72 West	Keyser Piedmont Stree	÷		Y⊈Yes 2 No
	the 28a- notif	Director	10e. Street and Number	10f. Zip Code		Citizen of What Co	untry?
	3a or		72 West Piedmont Street	26726		U.S.A.	
	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
0	after or ite		Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 □ XNo If Yes, Give		Rican, etc.)	Black, White	
2-0036	ral", c	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: D	lack
ဂ ဂ	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	ing 16b	. Kind of Business/I	ndustry
7	within lene. than " he Mec	nple	Elementary/Secondary (U-12) College (1-40r 5+)	re kind of work done during most of work DO NOT use retired)	- 1	т •	
7	filed w Hygier Ither th	ပ္ပ		look		lursing	Home
<u>n</u>	~ - 0 -	Be	17. Father's Name (First, Middle, Last) Robert Jackson	1	e (First, Middle, Maid Elizabe		
<u>\\ \</u>	2 should be and Menta Is marked raumatic ev	ပ္					
Maryland	l 2 sh n and r Is m			ling Address (Street and Number or Run			
	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition	West Piedmont		Location - City or	
Ö	Pages nent of h int; if lte		1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, cr	ematory or other place)		•	, -
Baltimore,	t. Pa tmer tant:			lli Crematory4/	19/08 Ըւ	ımberlan	d, MD
g	permit. Page Department of Important: If any Injury or once.			22. Name and Address of Facility Markwood Funera	1 Home,	Inc.	
174			23a. Part1. Enter the disease, or complet tions the caused the death. Do not e shock, or heart failure. List only one cause on each line.	P.O. Box 912, K	cyser, V	W 26726	
			shock, or heart failure. List only one cause on each line.	mer the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ri e	Physician		Immediate Cause (Final disease or condition resulting in death)				week
A Series	/Medical Examiner		Due to (or as a consequence of):	1 andres			2 weeks
		<u>_</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	· famdice			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•			
т.	be executed ician and burial-transit	xar	that initiated events c				
3		al E					
89	The law requires that the death certificate te has been signed by the attending physings 2 should be detached for use as the		0.				<u> </u>
XOA	certi nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of del	iverv
ň	atte	cial	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
٦ Ö	the or	ıysi	9 Unknown				
	s that ned b deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	quire; n sign ald be	d by	l'arkinsons lascese.		1 ☐ Yes	2 0 No 3 □ Pr	obably 4 Unknown
ပ္ပ	sw reg	Completed			24a. Was an	24b. Were au	topsy findings available
ž	The la	duc			autopsy performed	prior to death?	completion of cause of
<u>ra</u>			25. Was case referred to medical	26 Place of Deat	1 Yes 2 h (Check only one)	No 1∐Yes	2 □ No
	Physician: The lave this certificate has all director, page 2	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Impatient 2 ☐ ER/Outpati	Other	ome 5 Residence	e 6 DOther (Spe	cifu)
ō	g Phy er thi		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how i		cuy)
DIVISION	nding F ith. r: After e funer	tiol	1 Anatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
N S	Atte	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru	ural Route Number,
בֿ	s afte	Certification:	Full Holling, etc. (Opecity)		City of Town, 3	iaie)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier (Check only (Check only 1 Medical Examiner: On the basis of examination and/or				
	he H in 24 he F	Medical	and manner stated.	investigation, in my opinion, death occur	ried at the time, date	and prace, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	
			pytho	1)0033280		4pm (11	4,2001
			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	0.00	- 0.	~ >
			DR. Suni L Gupta 625 Kent :	Avenue Combe	MEMD IN	ND ON	200
	Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature	roll 1			
	Registi		APR 2 2 2008				
DH	MH 17 Rev 1/2	001					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Cornelia Lucretia Rodgers 9:55A.M APRII 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boonsboro

Year I If Under 24 Hrs. Min. Reeders Memorial Home Washington Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Months Yrs 86 Director 220-28-9180 9, 1922 April Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show a or 28a-f sh t be notified 1 X Yes 2 □ No Director Washington MD Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 84 Nottingham Rd. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important of Health and Mental Hygene. Important ferm 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Inspector Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Powell Shry Bertha Lee Lewis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Miner, Sr./Son 14938 Falling Waters Rd., Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 4/19/2008 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mark Su 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Oss rouchue Marc disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sequence of): Physician/Medical Examiner as the burial-transi Curgentie H
Due to (gr as a consequence of): attending physician Advanced IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner The law requires that the death certificate be executed

Maryland 21215-0036

altimore,

P.0.

Division or Vital Records,

Physician:

or Attending

this

After

s after death.

I Director: A

ed in by the fu

within 24 hours a To the Funeral I To the Hospital

filled in by

completely

page certificate funeral director,

Be

Certification: To

Medical

Other: 4 Nursing Home Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28b. Time of

autopsy 1□ Yes 2 (X) No 26. Place of Death (Check only one)

24a. Was an

5 🗆 Residence

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural
2 Accident 5 Pending 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) investigation

28c. Injury at Work? Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🛱 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

(Check only one)

46561

29d. Date signed (Month. Dav. Year)

6 ☐Other (Specify)

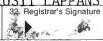
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311 LAPPANS ROAD GHAZALA QADIR, BOONSBORO, MARYLAND 21713

State Registra

31. Date filed (Month, Day, Year) 50000

edu



State of Maryland / Department of Health and Mental Hygiene

1- For State amend #5 Per FH G879 5/01/08 CHrtificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 14, P M April 2008 5:00 Raines Gene Larry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown 1634 Woodland Run If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 214-46-5061 **Funeral** Months 1**X** M 2□ F Oct.24, 1945 Washington DC Director 62 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show the notified at 10a. State 10b. County 1√2 Yes 2 □ No Director MD Washington Hagerstown 10g Citizen of What Country? 10f. Zip Code 10e. Street and Numbe items 23a oner must b 21742 1634 Woodland Run U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify Specify. 3 Nidowed 4 Divorced White Year or Dates Completed er than "nature the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Retail Warehouse Delivery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked o Calledith M. Reeder 2 Arthur D. Raines, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16951 Shadybrook Terrace, Hagerstown, MD item 27 i Judy E. Raines/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
important: If its
any injury or o
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, MD 4/17/2008 Rest Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 21742 1601 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shocks are the shocks of the shock of th Immediate Cause (Final MO **Physician** O month disease or condition resulting in death) Mo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2200 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 22/1/0 1 Tyes P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Magner of Death Certification: After 1 (Month, Day Year) Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Nam! 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

-DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	, roi	artment of Health and Men rtificate of Death	ntal Hygier Reg.	2000 10000
			Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physici		Sara Ruth Steinberg		pril 2,	2008 Year 5:40 A.M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LAGIIII	-	804 Amber Tree Court, Apt. 202	Gaithersburg		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Ye.	
	Director		220-14-5340 1 M 2 MF 82 Yrs.	Months Days Hours Min. (CT. 20.	1925 Maryland
	D		Usual Residence of Decedent			
	rylar	_	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits 1 X Yes 2 ☐ No
	e Ma	cto	Maryland Montgomery Gaithersb	ırg		1 ET 162 5 NO
	or 28	Oire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	23e	Funeral Director	804 Amber Tree Court, Apt. 202	20878		ited States
	swe swe	Ine	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36	or In	YFL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 X No Specify:		Specify:
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f ahow dicel Exar are mer must be predified at	d by	3 ★Widowed 4 □ Divorced Year or Dates:		1.05	wnite
5	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	160	. Kind of Business/Industry
12	withir ane. then	m d	Elementary/Secondary (0-12) College (1-4or 5+)	,		hans II am a
2	Hygie ther int, t		17. Father's Name (First, Middle, Last)	Maker 18. Mother's Name (Fig.		den Sumame)
an	ontal	9 Be	Morris Snyder	Adele Ida		,
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If item 27 Ia marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic event, the Medical Exartment to an experiment and once.	၉		ng Address (Street and Number or Rural Ro		tv or Town, State, Zip Code)
Ma	d 2 s th an t7 la trau		14920) Chestnut Ridge Cou	irt	,
	1 an Heal em 2		20h Mathad of Disposition 20h Place of Dispo	n Potomac, MD 20878 sition (Name of Date	20c	Location - City or Town, State
Ö	ages nt of :: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverda	Le Park April 7	⁷ ,	
Baltimore,	it. P.		Tremator	Cy 2008 Name and Address of Facility	Ki	verdale Park, MD
Ba	Deparent Indiana		7 - Can 100 Th	nibadeau Mortuary Se	rvice,	P.A. 10020
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	33 Gist Ave., LL, Si	iver Sp	Approximate
			shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or is.	apriatory arrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) Breast Cancer			
	/Medical Examiner		Due to (or as a consequence of):			
8		ايرا	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ed sit	oju	cause. Enter Underlying			
	and and Il-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	***************************************		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE				
687	icate phys s the	dical	d			
	ding se a	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	leath certific attending p	by Physician/Me	In the past 12 months:	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	the d	ysic	1 Yes 2 XNo 9 Unknown	Guilli (specify)		
	res that the death igned by the atte be detached for	hd.	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ds,	sign sign d be	d b)			1 🖺 Yes	2X No 3 Probably 4 □Unknown
Records,	w require been si should b	Completed			24a. Was an	Oak Mars substant findings qualishing
3ec	e tav has	mpl			autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
E F	r: Th				1 ☐ Yes 2 🗓	No 1 ☐ Yes 🌠 No
Vital	Physicien: The taw this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	26. Place of Death (Ci		
of	Phys this al dir	2	1 Tes 2 KNO 1 Inpatient 2 EH/Outpatier		5 X Residence Describe how in	
n	Jing I	ion	1 XNatural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	. Describe now i	njury occurred
Si	death.	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		Location (Street	t and Number or Rural Route Number,
Division of	l or Attendater deatl Director:	Certification:	4 Homicide determined building, etc. (Specify)	eet, ractory, office	City or Town, S	tate)
	pitel ours erel filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deat	a good grad at the time, data and place, and	due to the cause	o(s) and manner as stated
	Hos Pun Fun stely	Jica	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s)
	To the Hospitel or Attending Physicien: The Within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F 3 F 8		MA			
	5			D35635	Ap	oril 2, 2008
			30. Name and address of perty, who completed cause of death (Item 23a) (Type, Joseph Kaplan, M.D., 18111 Prince Ph.)7 Olma	w MD 20832
			31. Date filed (Month, Day, Year)	trip brive, suite 32	., orne	у, гш 20002
	Sta Registi		APR 0 7 2008 April 1 Signature	50		
	riogisti		APK U (LUUO) COLOR OF STATES			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day March 30, 2008 1444 Samuel M. Sasu 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 X M 2 ☐ F Vrs September 15,1938 Ghana 578-86-9723 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 X Yes 2 □ No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20879 U.S.A. 19237 Wheatfield Terrace 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 🗷 No Specify 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hote1 House Attendant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amma Tutuah Martin Tawia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19237 Wheatfield Terrace, Gaithersburg, Maryland 20879 Comfort A. Sasu - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/03/2008 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 2 days Aspiration Pneumonia disease or condition resulting in death) Due to (or as a consequence of). 6 days CVA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be Medical Certification: To

29a. Certifier

iptial or Attending Physician: The law requires that the death certificate be executed ours after death. earal Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital o within 24 hours aft To the Funeral Di

Division or Vital Records, P.O. Box 68760,

_	Malnutrition										1 ☐ Yes 2 万	No	3 ☐ Proba	ably	4 Unkno	wn
							_				24a. Was an autopsy performed? 1₺ Yes 2□No	24b.	Were autop prior to con death? 1 X Yes	osy find npletion 2 \(\square\) No	n of cause o	ble of
25.	Was case referred to me	edical	26. Place of Death Check onl one													
	examiner? 1 ☐ Yes 2 🔀 No	Н	ospital: 1 🗷 Inpatient	2 🗆 E	R/Outpatient	3 🗆 [DOA O	ther: 4	☐ Nursing I	lome	5 ☐ Residence 6	□Ot	her (Specify	·)		
		Pending nvestigation	28a. Date of Injury (Month, Day Ye		28b. Time of Injury	М	1	ork?	2 □ No	28d. Describe how injury occurred						
		Could not be letermined	28e. Place of injury building, etc. (5	At hor Specify	me, farm, stree	t, fact	ory, office	9		28	f. Location (Street and City or Town, State)	d Num	ber or Rura	Route	Number,	

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0053654

march 30, 2008

ess of person who completed cause of death (Item 23a) (Type, Print)

, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 ZHU 40

State Registrar 31. Date filed (Month, Day, Year) APR 0 7 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** March 31, 2008 1430 P M Edward Spates Maurice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Frostburg Village Nursing Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours Months 1 X M 2 □ F 82 10/07/1925 Maryland 219-14-7085 Director Usual Residence of Decedent 1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Cumberland Allegany Funeral Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2185 Shades Lane (P.O. Box 676) 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No 1944 — If Yes, Give Year or Dates: 1946 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Saltimore, Maryland 21215-0036 Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Smith Spates ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2185 Shades Lane (P.O. Box 676), Cumberland, MD 21502 Lessie L. Spates / Wife permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Buriał 2 【Cremation 3 ☐ Removal from State Cumberland Crematory 04/02/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CIRAHUSIS Sow 8 years Physician /Medical Due to (or as a consequence of): Examiner PCLE RUSING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₩ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate has page 2 s 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) or Attending 1 Aatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide filled in by 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hadm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road, Cumberland, MD Harjit S. Sidhu, M.D., 31. Date filed (Month, Day, Year) State APR 0 2 2008 Registrar

State Registrar

APR 0 8 2008

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Florence Elizabeth Snyder 2008 2:45 PM April 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood of Williamsport Williamsport Washington If Under 1 Year If Months Days F 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs Hours Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 21X F Director 93 212-38-7549 Nov. 26,1914 | Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

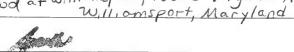
ther than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be r 16505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No by Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Food Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Thomas Charlton Mary Alice Reid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaRue A. Fox/Daughter 9634 Cafoxa Drive, Williamsport, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 4/12/2008 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma month /Medical Due to r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 Frobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) april 9,2008 Cypthia Kuttner-Sands, no D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 11, amsport, 16505 Virginia Avenue Cynthia Kuther-Sands, ND Homewood at W.11, amsport, Maryland 21795

State Registrar 31. Date filed (Month, Day, Year)

APR 1 1 2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /		rtment of tificate o				Reg. No.	800	13103
48	Physici	an	1. Decedent's Name (First, Middle, Las						1	2. Date of Dea	Day	Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give		AIN	17	4b. City, Town	or Location	ol Death	4 pri		Z005	
	Examir	ier	ASSISTED LIV	ING W	01-1		Sove	NA	PAI	2K	A	VAVO U	4 punner_
	Funeral	27.2	5. Social Security Number 6. S	9x 7. Ag	e (In yrs. last b		If Under 1 Year Months Day		Min	8. Date of Birt	h v. Year)	Co.	hplace (State or Foreign untry)
547	Director		215-07-1069 ¹	UM 2015	89	Yrs.	WOTHING Day		5	Month, Da Sept. 1	3, 19°	18 Mar	ryľand
	land ow		10a. State 10b. County		10c. City, To	wn or Loc	ation			···			10d. Inside City Limits
	the Marylan 28a-f show cotified at	į	MD Anne Aru	ndel	Mil	llers	ville						1 ☐ Yes 2 7 □4No
	ath with the 23a or 28	ai Dire	10e. Street and Number 271 W. Pasadena	Rd.			10f. Zip Code 22108				10g. Citizen USA	of What Co	untry?
980	after des or items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 24 If Yes, Give Year or Dates:	Ever in U.S. No	1	as Decedent o Yes, specify Co			ify Yes or No- lican, etc.)		Race - Ame Black, White ecity: Whi	e, etc.
21215-0036	should be filed within 72 hours nd Mental Hygiene. marked othar than "natural", imatic event, the Medical Exe	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or t	5+)	(Give k life. D	ent's Usual Occ ind of work dor O NOT use reti	upation ne during mo: red)	st of workin	g		of Business/	Industry
	iled w Hygier Thar th		12 17. Father's Name (First, Middle, Last)		Ho	omema	ıker	18 Moth	ar's Nama	(First, Middle,	Own .		
Maryland	2 should be filed with and Mental Hygiene. Is marked othar than aumatic event, the	o Be	Robert Pressler						Hobe.		Malden Sul	nainer)	
aryi	shoul nd Me mark	2	19a. Informant's Name/Relationship	Type, Print)	19	9b. Mailing	Address (Stre				er, City or To	wn, State, Z	Zip Code)
2	and 2 salth ar n 27 is	3.	Antonio D. Traina	/ Son			Stratfo		rk Pl	. #408	Rest	on, VA	A 20190
Baltimore,	permit. Pages 1 and Depertment of Health Important: If Itam 27 sny Injury or other tr <u>once.</u>		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State			ition (Name of atory or other p		Da			on - City or	
I i i	permit. Par Depertmen Important: sny Injury once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	()	Arling		Nat'l (4/30/2		Arlin	-	VA
Ba	permit. Depertr Importa any Inj		21. Signator of Andrai Service Clear	Dodda)	22.	6512 N				wie,M		15
	Physician		23a. Part1. Enter the disease, or comshock, or heart lailure. List only Immediate Cause (Final disease or condition	one cause on each li	the death. Done.		r the mode of d						Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	b	a consequence	·							
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence								
8760,	sate be ex physicien a the burial	cai	L	d	a consequence	e or):							
P.O. Box 6	The law requires thet the death certificate be executed ale has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregna: Other (specify)				23d.	. Date of deli Month	ivery Day Year
	uires thet signed t Id be dett	۵	Part II. Other significant conditions of CHRONIC OB		_			given in Part			obacco use Yes 2□N		the cause of death?
Records,	sician: The law require s certificete has been sid lirector, page 2 should b	Completed									osy ormed2		ntopsy findings available completion of cause of
Vital	ian: intifice ctor, p	BeC	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes (Check only o	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 10
of V	Physician: r this certific ral director,	2	examiner? 1 Tes 2 10	Hospital: 1 Inpatie			3L) DUA			e 5 Resid			city) wind
ou c	ding P	ilon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Oate of Inju (Month, Da	y Year) 28b.	. Time of Injury	28c. In W	juryat Vork? □Yes 2□		8d. Describe I	how injury o	ccurred	
Division	or Attendii efter death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, c. (Specify)	larm, stre			2	8l. Location (S City or Tox		umber or Ru	ural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificete his perpetent filled in by the funeral director, page	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination a	ge, death and/or invi	occurred at the estigation, in m	time, date a y opinion, de	nd place, a ath occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11.				ense number					h. Dey, Year)
	(5)		Munt	yyn	117		D	4636	o C		APPRIL	7,20	008
	(1)		30. Name and address of person who	completed cause of c	leath (Item 23a	Type, F	Print)	Higus.	and	Tuso	111101	MOZ	1108
33	Sta	ate	31. Date filed (Month, Day, Year) APR 0 8 2008	32. Registr	ar's Signature	- 1	- LANGE	···	41	1 200 10 30	,,,,,		100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> Month 9:00 P M April 4, Η. Turner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 □ M 2X North Carolina Sept 3 1928 579-38-7249 79 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2X No Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 USA 8308 Fairhaven Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 9 Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) Catherine Roy Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Gilchrist/daughter 8308 Fairhaven Drive Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04/07/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784MD 21029 Beverly L. Heckrotte, P.A. Clarksville. MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fathere. List only one cause on each line.

Physician /Medical Examiner

permit. Pages Department of Important: If its any Injury or o

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show be notified at

"natural", or Items 23a dical Examiner must b

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The strain and Mental Hygiene.
The marked other than "natural", or Items 23, ant; If item 27 is marked other than "natural", or Other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Director MD

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Iding physician and ise as the burial-tran use signed by the a has certificate has irector, page 2 I Director:

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours aft

To the Funeral DI

completely filled in

	disease or condition	a Lung Co	ncer		14001	
	resulting in death)	Due to (or as a con equence of):				
iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a consequence of):				
ical Examiner	that initiated events resulting in death) Last	C				
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Yea	àr
ed by Ph		ontributing to death but not resulting in the underly	ying cause given in Part I.		o use contribute to the cause of deat	
Complet	chronic ob	stucture pulnoney	dijear	24a. Was an autopsy performed 1 Yes	24b. Were autopsy findings ava prior to completion of caus death? No 1 ☐ Yes 2 ☐ No	ailable se of
Be (25. Was case referred to medical		26. Place of De	eath Check onl one		
	examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: Nursing	Home 5 ☐ Residence	6 □Other (Specify)	
ation:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Numbe ate)	r,
Medical Certification: To	29a. Certifier Certifying Ph	niner: On the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)	

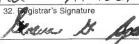
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State Registrar 31. Date filed (Month, Day, Year) APR 0 9 2008

address of person who col

John

30. Name and



npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For Stata Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2008 **Physician** $1\tilde{2}$ 3:45 A J Thompson Matilda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Caroline Denton Caroline Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 21 | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Pennsylvania **Funeral** 1917 1 ☐ M 2 🛛 F 91 Yrs 218-50-1903 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Examiner must be nutified at Yes 2 No Denton Maryland Caroline Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 501 Kerr Ave. death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 □ Divorced Year or Dates natural al Hygiene. I other than "nature event, It is Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Package goods store owner/operator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event gans. Susan Pataki Racz Joseph Racz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 495 Wampee Street NW; Calabash, NC 28467 Donald Thompson/ son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04/16/08 Barclay, Maryland Busick Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee Fleegle and Helfenbein Funeral Home, PO Box 160; Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CUMON Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or se a consequence of) Examiner To the Hospitel or attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes certificate 26. Place of Death (Check on one director, Be 25. Was case referred to medical examiner? Cther: 4 Jurising Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of completely filled in by the funeral After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident dear 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide afte within 24 hours a To the Funerel L 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year) APR 1 6. 2908

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Manthail Day-BOASS 06:00AM Helen Geraldine Tucker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 369-44-3000 92 Director 1916 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Director MI Hastings Barry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49058 1010 S. Broadway U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 School Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernie Skidmore Glenna Houghtalin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Gradowski, Daughter 1320 Rayville Rd., Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 19, 1 X Burial 2 ☐ Cremation 3 X Removal from State Striker Cemetery Hastings, Michigan 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licensee Mill W! Meunane 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMALL BOWEL OBSTRUCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ISCHEMIC BOWEL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit CHRONIC ATRIAL FIBRILLATION resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DEMENTIA 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? STROKE 2000 1□ Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) D37254

State Registrar

DHMH 17 Rev 1/2001

TOWSON, MARYLAND 21204

7601 OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

BOON POH LIM.

31. Date filed (Month, Day, Year)

08-025	28		
Harold	Louis	Turner	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate Registrar	of Death	Reg.	No.		
Physicia	ın/	Decedent's Name (First, Middle,Last)	Turner	Date of Death Month D	ay Year	3. Time of Death 0629 hrs	
Medical Examir		Harold Louis 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	March 31, 20	008 4c. County of Death		
		Western Maryland Health System	Cumberland		Allegany		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 120-52-7590 1 XM 2 F	Yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min		10/17 Co	thplace (State or Foreign untry) aryland	
MD 21215-0036 at 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show any animatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	Yrs. pocation ville 10f. Zip Code 15535 Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: edents Usual Occupation (Give kind of any most of working life. DO NOT use ret Inspector 18.Mother's Name Vera ailing Address (Street and Number or 459 Flintstone Cree sposition (Name of cemetery,	pecify Yes or No- Rican, etc.) work done ired) e (First, Middle, Ma Hele Rural Route Number Road,	Citizen of What Cou USA 14. Race - Amer White, etc. Specify: 6b. Kind of Business, State Hwy iden Surname) n	10d. Inside City Limits 1 Yes 2 No ntry? ican Indian, Black. White Industry Admin. Fetters e, Zip Code) e, PA 15535	
Baltimore, permit. Pages 1 at Department of He. Important: If ite		A Departies 5 Other Specific MD Vet (or other place) Cem @ Rocky Gap 04 22. Name and Address of Facility AC	ams Famil	y Funeral	Home, P.A.	
		23a. Fat L. Enter the disease, or complications that caused the death. Do not en	404 Decatur Stree			21502 Approximate Interval	
Physician /Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sharp Force Injury of Head Due to (or as a consequence of):	iter the mode of dying, sour as cardiac (or respiratory arres	i, shook, or mount	Between Onset and Death	
		Sequentially list conditions, b				-	
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od sit	xan	events resulting in death) Last Due to (or as a consequence of):					
executed in and i transit		d. UNPENDED AMENDED					
Box 68760, e death certificate be executed the attending physician and of for use as the burial - transi	ıysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves. 2 No.9 Unknown	Fetal death 3 Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year	
P.O. es that the igned by t	by Phy		the underlying cause given in Part I.			o the cause of death?	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Completed b			24a. Was ar autopsy perform 1 • Yes 2	24b. Were a prior to death?	autopsy findings available completion of cause of	
ital sician: s certi	Be	25. Was case referred to medical examiner?	26.Place of Death (Check atient 3 DOA Other;4 Nurs		esidence 6 Oth	er:	
Natural 5 Pending Investigation 2 Ves 2 No Inpatient 3 DOA 4 Norsing Home 5 Residence 6 Other: 28a. Date of Injury Mar 31, 2008 28b. Time of Injury 0516 hrs 1 Yes 2 ✓ No Subject assaulted							
Divisi spital or Att nours after de neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family Hor	ne	or Town, Sta 2459 Flintstone	te) Creek Road, Clea		
To the Hos within 24 h To the Fur completely	Medical		occurred at the time, date and place, an stigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)	
To the within 2 To the Complete	Med	and manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (h		
5+		30. Name and address of person who completed cause of death (Item 23a)					
nds		COO Do into the Company	Penn Street, Baltimore, MD 21	201			
St Regis	tate trar		Scarle)				
DHMH 17 Rev 1/2	001	ORIG					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Apri 1095 - Goldblatt 50 AM 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PriNCE VATTSVILLE FORCE GEORGES 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 8, 9. Birthplace (State or Foreign Social Security Age (In yrs. last birthday New Months 1 □ M 2 🔀 F York 88 Yrs Sept 134-16-3686 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 USA 3321 Stanford Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Kaiser Augustus Voss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan A. Goldblatt/son 3321 Stanford Street Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory | 04/08/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseq uence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IE FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in 23e. Did tobacco use contribute to the cause of death? the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

P

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

25. Was case referred to medical examiner?

Hospital:

5 Pending investigation

6 ☐ Could not be

1 Inpatient

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

4 Homicide

MD

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It hand Mental Hyglene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be 1
Department of Health and Mental 1
Important: If item 27 is marked of any injury or other traumatic eve

Maryland 21215-0036

Baltimore,

physician and s the burial-trans attending p ed by the a detached f signed t page 2 s certificate has

that the death certificate be executed

Box 68760.

Records, P.O.

Division or Vital

he Hospital or Attending Physician: in 24 hours after death. he Funeral Director: After this certifica piletely filled in by the funeral director, p

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANGO NASTEEN TAKOMA AUE WP 32 Bedstrar's Signature 31. Date filed (Month, Day, Year) APR 09 2008

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amenc#2. PerPhys. PC4-16-08cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day**01,** Year 2nd 2008 Month **Physician** Μ. Wells Shirley 4:40 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Fort Washington Hospital Wash Prince George 8. Date of Birth (Month, Day, Year)
April 17) 931 Wash DC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 76 578-44-3478 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Washington DC 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3005 Bladensburg Rd NE#216 20018 USA r than "natural", or Items 23: the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygience Important: if item 27 is marked other that any injury or other traumatic event, the once. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Clark Thurman Dade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7247 Mahogany Dr. Landover, Md 20785 DiAnne M. Wells (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem Park April8,08 Landover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Savice Licenses 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NWWashDC 23a. Part1. Enlegthe disease, or complications that caused the death, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Mota ste h Den amon Due to (or as a consequent e of): ull Physician Concenone /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed burial-trar that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the ar 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ þe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' this certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Mnpatient 2 ER/Outpatient 3□ D0A 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural (Month, Day Year) Injury within 24 hours after occur.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1) 0055 120 SE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Richard Palmer

31. Date filed (Month, Day, Year)

APR 0 8 LUUS

MD 1328 Southern au

32. Re

Se Sunte 310

Washingkin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Wagner 10:02 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** niversita N/A Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 MM 2 □ F Director 11/20 Maryland 220-19-7430 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. In ent of Heath and Mental Hygiene. The stress 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant; If ether traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Acamack Greenbackville VA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23356 USA 37362 Doubloon Dr. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 Ho Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Inspector Housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linda Hudson Jeffrey W. Wagner, Sr. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kelli N. Wagner / Wife 37362 Doubloon Dr. Greenbackville, VA 23356 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gards. 4/10/2008 Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Beall Funeral Home apa 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final VENIC1 & **Physician** motor disease or condition resulting in death) /Medical Due to (+ as a consequence of): Examiner trauma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PROPERTY APPROPERTY BEAUCH ELIMIN Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleah.

Ye the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ivitra abdom Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ failurg 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nypertansion autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ^o 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 5 ☐ Pending investigation 1 Natural 28e. Place of injury - At home, farm, street, factory, office building etc. (Specify) Subject driver auto-auto Collision 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. L. lation (Street and Number or Rural Route City of Jown, State) NB Snow Hill Rd Gille 4 Homicide Koadwa 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho

State

Registrar

S. GrEENE

22

32. Registrar's Signature

Baltimore, MD

Labbs

m12/12

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 4:15 A 04 Joan C. White 05 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wiconico Jalisbury If Under 1 Year | If Under 24 Hrs Coastal Hospice at The Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex 1271871935 Months 1 □ M 2 T F 72 NY 100-28-7267 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Princess Anne MD Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21853 30539 Creek View Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black White etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Copper works Copper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hans Meyers Irmgard Becker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30539 Creek View Dr., Princess Anne, MD 21853 R. Donald White / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4/7/2008 Frankford, DE Cape Henlopen Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 🗷 No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | HTS pice Hospital: 1 ☐ Yes 2 Mo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

The law requires that the death certificate be executed and as the burial-trai Division or Vital Records, P.O. Box 68760, attending physician certificate has or Attending Physician: After this

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

State Registrar

Funeral

Director

77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce.

Physician

/Medical

Examiner

the Maryland

death with

1 and 2 should be filed within 72 hours after the Health and Mental Hygiene.

and

Baltimore, Maryl

within 24 hours after death.

To the Funeral Director: Aft

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4 Homicide

(Check only one)

29b. Signature and title of certifier lella)

and manner stated.

D 29505

Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

APR 0 8 2008

State of Maryland / Department of Health and Mental Hygie Certificate of Death

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No.	۲.	U	U	U	i	U	i	1	0

	Physici		1. Decedent's Name (First, Middle, RONALD CRAIC							2. Date of De Month	Da	y 2	Year	10:30A	
	/Medic Examin	100	4a. Facility Name (If not institution,		RSING		4b. City, Town, o			LLAGE	4c.		of Death		
100	Funeral Director		213-66-2356	6. Sex 7. Age	53	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay Year) 2	954	9. Birthplac Country	ce (State or Forei MD	gn
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MONT	rgomery	10c. City, Town		cation RSBURG						100	l Inside City Limi	
	death with the Maryland ms 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 12 S. FREDER			10g. Cit		What Country SA	/?						
920	urs after deat al", or items (xaminer mu	by Funeral	11. Marital Status 1 対 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ed 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. No		Vas Decedent of I f Yes, specify Cub ☐ Yes 2 No	res, specify Cuban, Mexican, Puerto Rican, etc.)					ce - Americar ck, White, et by: WHI	э.	
9500-61212	Juithin 72 hours after death with the Marylar jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of w								МО	NTG	usiness/Indu OMERY NMENT	COUNT	Y
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, mar	and 2 should satth and Mer n 27 is marke er traumatic	•	19a. Informant's Name/Relationsh ROBIN WISEMAN		12	2 S	g Address (Street	ERICK	AVI	E., #1	08,	GA	ITHER	SBURG,	7 МІ
baitimore,	Pages 1 and ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1				sition (Name of natory or other pla Y CEMET					ation - City or Town, State LLSVILLE, MD			
Dail	permit. Pag Department Important: I' any injury o		21. Signature of Funeral Service	M		H	Name and Addr ILTON I O BO	FUNER	RAL I	NESV	LLE	, м		838	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused only one cause on each lin										Approximate nterval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)		a consequ <i>e</i> nce o	of):		VASC	OLAK	DISE	ASE				-
L	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CONGEST	a consequence TVE HE	ÅR.	r FAILU	RE							
68/60,	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of): CORONARY ARTERY DISEASE d.												
O. Box 6	death ce e attendii id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown										ate of delivery	, day Year	
JS, F.	The law requires that the tte has been signed by thoage 2 should be detache	by	ODGEDUGETUE GIEED ADNEA									. 9		cause of death?	wn
ecords,	w requires to been signer should be a	leted	OBSTRUCTIVE SLEEP APNEA HYPERLIPIDEMIA								s an	-		sy findings availal	_
100	The law	Completed	HYPOTHYROID			aut	opsy formed? 2 N		prior to com death? 1 ☐ Yes 2)f				

Division or Vita To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Be

2

Certification:

1 - For State Registrar

25. Was case referred to medical examiner?
1 ☐ Yes 2 ★ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

29c. License number D41162

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

APRIL 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19529 VINU GANTI, MD DOCTORS DR. GERMANTOWN, MD 20874

State Registrar

		State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008									
-4 1 1 m	Я	1. Decedent's Name (First, Middle,	Last)					2. Date of De		Vear	3. Time of Death
Physic /Med		Mary	L	ou		Watson		MARCH	1 27,	2008 ^{Year}	17:20 M
Exami		4a. Facility Name (If not institution, WMHS - MEMOR	_				Location of Death	1	4c. C	ounty of Death ALLEGAN	NΥ
Funeral		· · · · · · · · · · · · · · · · · · ·	6. Sex	7. Age (/	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth	olace (State or Foreign
Director		161-28-9853	1□M 2∏F	73	Yrs.	Working Bays	110010	12/31/			nsylvania
and w		Usual Residence of Decedent 10a. State 10b. County		10	0c. City, Town or Lo	ocation					10d. Inside City Limits
Manyla f sho	ō	MD A	llegany			umberland	1				1 TYes 2 □ No
r 28a- notif	Director	10e. Street and Number	Liegally			10f. Zip Code			10g. Citize	en of What Cou	ntry?
h with 23a o		537 Haddo	on Avenu	е			21502			USA	A
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was De Armed I		er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	D- 14	 Race - Americ Black, White, 	
s after	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, 0	3 2 XNo Give		1 ☐ Yes 2 ☐ No	Specify:		8	Specify:	
hours tural'		15. Decedent	Year or	Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/In	White
in 72 in "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor i)	king			
d with giene rrtha	E	12	College	(1-40/ 34)		Secretar	У			Church	
al Hy al Hy svent,	Be	17. Father's Name (First, Middle, I	.ast)	M - T	77		18. Mother's Nar	ne (First, Middle	e, Maiden S		1
should be and Mental marked o	2	Ralph		MCI	Farland		Mary			Hoagla	
VICES SH and hand rise m		19a. Informant's Name/Relationsh Richard L. Wat		h o n c		ng Address (Street				•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition	SOII / III			Haddon Av osition (Name of matory or other place)		Date		21502 ation - City or T	
Pages 1 rent of He nt: If iten		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		m State		<i>matory or other plac</i> emorial P	1	1/2008	Cumb	erland	MD
nit. Frankmenten		21. Signature of Funeral Service I									Home, P.A.
Departing Departing any Irreported and Irreported any Irreported any Irreported any Irreported any Irreported any Irreported any Irreported and Irreported any Irreported and Irreported any Irreported any Irreported and Irreported and Irreported any Irreported and Irreported a		Klimx	Udan	26		04 Decatu					1502
		23a. Part T. Enter the disease, or shock, or heart failure. List	complications tha	t caused the	e death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a GANO	GRENE	SMALL &	LARGE INT	TESTINE				Onset and Death 4 Weeks
/Medical Examiner		resulting in death)	Due t	o (or as a c	consequence of):						
LXammer		Sequentially list conditions,	D		ic Artery	Atheroso	clerosis				Years
nted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			, on o o o o						
be executed ician and burial-transit	Exal	that initiated events resulting in death) Last	c Due t	o (or as a c	consequence of):						
cate be executed physician and the burial-transit	dical		d								
ng ph	Med	IF FEMALE:									
ath cer ttendin or use	lan/	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal death 3	Ectopic pregnancy	/		23	3d. Date of delive Month	/ery Day Year
the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9□Unl		me of death 5	Other (specify) _					
that the ed by detac		Part II. Other significant condition	ns contributing to	death but i	not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
w requires to been signed should be	d by	Coronary Arte	ery Dise	ase w	ithout In	farction		1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown
w rec	lete	Pulmonary Emi	olism					24a. Was		24b. Were aut	opsy findings available ompletion of cause of
The la	Completed	Renal Failure	<u> </u>	_				perf	opsy formed? 2 X No	death?	2 □ No
vitalicalical	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
Physic rthis ce	다 단	1 ☐ Yes 2 📉 No			2 ER/Outpatie		4 Li Nursing r	Home 5□Res			ify)
ing P		27. Manner of Death 1.★Natural 5 Pending) (M	te of Injury onth, Day	Year) 28b. Time (Wor		28d. Describe	how injury	occurred	
ttend death stor: /	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	ice of injury	At home, farm, s		Yes 2 □ No	28f. Location	(Street and	Number or Ru	ral Route Number,
lor A after Direc	Certification:	4 ☐ Homicide determi	ned bui	ilding, etc.	(Specify)	,,,		City or To	own, State)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the 1	Medical C	29a. Certifier Check only one)	Examiner: On the	the best of e basis of e anner state	my knowledge, dea examination and/or i	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) a	and manner as place, and due	stated. to the cause(s)
o the	Mec	29b. Signature and title of certifier		7/	7	29c. Licens			29d. Date	signed (Month	, Day, Year)
7		* Stura	(X	SKA	44	D00	18216		Ma	rch 28,	2008
ap		30. Name and address of person	who completed ca	ause of dea	ath (Item 23a) (Type	, Print)					
		Steven R.				on Drive,	Cumber1	and, MD	215	02	
	tate	31. Date filed (Month, Day, Year)			's Signature						
Regis DHMH 17 Rev 1		MAR 2	8 2008	193-0	w B	parte					
HWILL IT REV I.	2001					,-					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month p^{M} 2008 1:00 8, Walter William Wraga April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number 6. Sex Hours Months 1**X** M 2□ F 90 Feb. 10,1918 New Jersey 158-03-9018 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 USA 10,000 Brunswick Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 21☑ No Specify 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Teopila Sikorska Jan Wraga 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2917 Terrace Drive, Chevy Chase, Md. 20815 Barbara D. Barry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory 4/10/2008 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 21. Sig Mare of Funeral Pervice Licens 22. Name and Address of Facility Rest Haven Funeral Chapel he 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Acute Myocardial Infarction 1 Day Due to (or as a consequence of): Coronary Artery Disease Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clia to for as a consequence of: 5 Years Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 21 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

funeral

After t if or Attending Fafter death. Director:

To the Hospital within 24 hours a To the Funeral L Hospital

Funeral

Director

should be filed within 72 hours after death with the Maryland of Mental Hygiene.

and Ked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "Natural".

s 1 and 2 should be fil Heaith and Mental H tem 27 Is marked otl

permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is any injury or other trau once.

Saltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

the death certificate be

burial-transi attending physician for use as the buria signed by the a this

IF FEMALE: 25. Was case referred to medical

23h. Was decedent pregnant

Cancer of Bladder, Obesity, Malnutrition

autopsy performed? 1 Yes 2 No 26. Place of Death Check onl one

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No

4/9/2008

1 ☐ Yes 2 🔀 No	Ho	ospital: 1 🔀 Inpatient 2	BR/Outpatient	3 🗆 E	OA Other: 4	☐ Nursing H	ome 5 Residence	6 ☐Other (Specify)
2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how inju	ury occurred
	Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, stree	t, facto	ory, office		28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)

determined 4 Homicide 29a. Certifier

(Check only one)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D53367

29b. Signature and title of confifier

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rajan Shyamsundar, 9801 Georgia Avenue, Silver Spring, Md. MD

State Registrar Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistraMEND#20loperFH4-11-08, BMW, MbCo Reg. No. 1. Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** Ruby Eilene Yoho April 5, 2008 11:52 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arcola Health & Rehabilitation Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2XXF 76 West Virginia Director 232-52-0135 Jun 17, 1931 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location show 10a. State 10h. County ral", or items 23a or 28a-f shor Examiner must by notified at 1 ☐ Yes 2 No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 4410 Oglethorpe Street #104 20781 LISA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced natural" Completed 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Administrative Assistant other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be ၉ Earl L. Yoho Helen Gamble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Hea Virginia Lee Smith /Friend 6200 Westchester Park Drive, #604, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State I III 4-9-08 BuchallanderHin19 of the 1 X Baria 3 Removal from State 2 Cremation permit. Page Department of Important: If any Injury or once. 8, 2008 4 Dona 5- Offer Spe Allen Grove Cemetery Moundsville, West Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Idiopathic pulmonary fibrosis 5 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Day Month Year Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes Mellitus, Cirrhosis of Liver, 2XX No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease, Congestive Heart Failure, 24a. Was an autopsy 2**X**No 1 ☐ Yes 2 🗆 No Failure to Thrive 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident after death Director: by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Records, of Vital Division filled in 24 hours a within 2 the 0

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and litle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Shyamsundar Rajan 9801 Georgia Ave, Suite 117, Silver Spring, MD 20902 31. Date filed (Month, Day, Year)

APR 0 8 2008



1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D5337

29c. License number

29d. Date signed (Month, Day, Year)

April 7, 2008

			For State Registrar	State of Maryland /		nent of He	eath	Reg	4000	13117
	Physici		Decedent's Name (First, Middle, Last)	Jennie ZUCKERM	AN			2. Date of Death April 2	2 Day 2008 Year	3. Time of Death 8:30 P M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give st 4701 Willard Avenu 5. Social Security Number 6. Sex 10		irthday) If		Chase If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death Montgome 9. Birth	place (State or Foreign ntry)
	Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	10c. City, Tov	wn or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	ai Director	10e. Street and Number 4701 Willard Avenu		1	Of. Zip Code	20815		Citizen of What Cou United Sta	
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examirar mant te rediffed at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 20 □ No If Yes, Give Year or Dates:		Decedent of His s, specify Cuban Yes 2 No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
9500-61212	l within 72 ho jiene. r than "natur ihe Medical"	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation (completed) 166 College (1-4or 5+) R	a. Decedent (Give kind life. DO t Restau	s Usual Occupat f of work done di NOT use retired) ranteur	ion iring most of workir	ng 16	Restaura	
_	uld be filed Aental Hygic rked other tlc event, II	To Be C	17. Father's Name (First, Middle, Last) David Wolfm				18. Mother's Name Devo			
Mary	and 2 should I aith and Meni 27 is marke er traumatic		19a. Informant's Name/Relationship (Typ Louis Zuckerman, So	0.0	b. Mailing Ai	imens #6	od Number or Rura	Route Number, (Laurent,	City or Town, State, Zi Quebec, C	, _{Code} H4R 2B1 anada
Baltimore,	permit. Pages 1 and 2 should be Departiment of Health and Menis Important: If item 27 is marked any injury or other traumatic e one.		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funetal Service License	Baron	De Hi	me and Address	netery 04	/06/08 M	am o	own, State Juebec, Can.
fr _i	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do	254 not enter th	Carroll De mode of dying	St. NW., such as cardiac o	Washine respiratory arres	tton, DC /	2012 Approximate Interval Between Onset and Death
人 人	/Medical Examiner system and he burial-transit	edicai Examiner	resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Aortic Stenosi Due to (or as a consequence Due to (or as a consequence	e of): ÎS ∍ of):					
P.O. Box 6	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		opic pregnancy her (specify)			23d. Date of delin Month	very Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions conf	ributing to death but not resulting	in the under	lying cause give	n in Part I.		cco use contribute to	V
Division of Vital Records,	: The law recate has bee	Completed						24a. Was an autopsy perform 1 ☐ Yes 2	ed? death?	opsy findings available ompletion of cause of
<u> </u>	sician: Th certificate irector, pag	Be c	25. Was case referred to medical examiner? Y	ospital: 1 Inpatient 2 ER/0	Outpotiont (Othe	26. Place of Death		ce 6 □Other (Spec	(6.1)
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		. Time of Injury	28c. Injury Work M 1 Y		28d. Describe how		
DIX	ital or Att urs after de ral Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Town,		
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medicai	(Check only 2 Medicel Examinone)	ician: To the best of my knowled er: On the basis of examination a and manner stated.		igation, in my op	inion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
1	4	2	29b. Signature and title of certifier	The the		29c. License			d. Date signed (Month	
	\		30. Name and address of person who co Gary M. Koritzinsk	y, M.D., 2141 K	St.,	NW, #40	7, Washi	ngton, D	20037	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 7 200	32 Registrar's Signature	Space	E				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE OF Maryland bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ALALAW W09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERGITY OF MARYLAND BALTIMORE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** N/A 1 M 2 □ F Months Days Hours 59 Yrs Director May 5, 1948 Kuwait Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If Iten 23 is marked other than "natural", or items 23a or 28a-f show any halvy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits N/A n/a Hanefah, Kuwait Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Block 10 House 1 Area 100 Street Abu Kuwait Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Sayed - Husein Al-Alawi Khadeiah Oasem 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hishmah Al-Mousawi / Wife Block 10, House 1 Area 100 Street Abu, Hanefah, Kuwait 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Al-Sulaybekhat 04/25/2008 Kuwait City, Kuwait 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. W. Maus 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRAVMATIC BRAIN **Physician** /Medical Due to (or as a consequence of) Thim Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) sion or Vital Records, P.O. Box 68760, Physician/Medical DENTIFICATION AND attending pl 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> END STAGE RENAL DISEASE 1 Tes 2 No 3 Probably 4 Unknown Completed LEVKEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform or Attending Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation 2008 Unknown FAU 1 ☐ Yes 2 XNo after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 406 Hibassy Circle 4 | Homicide To the Hospital Apt. 304 Owings Mills, MD 21117 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 7 SOUTH GREENE STREET, BAUTMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 3 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE WAY DESTRUCTION OF Health and Mental Hygiene 2 1 1 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 20, 2008 Year **Physician** 10:15 ам Freedom Hutchinson Ainsworth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Sykesville Coper Ridge If Under 1 Year | If Under 24 Hrs. 8 Pate of Birth Day, JUL 13, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ★M 2 ☐ F 92 1915 Massachusetts 061-12-7965 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director Sykesville Maryland Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21784 710 Obrecht Road 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Saltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineering Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Ainsworth Eleanor Hutchinson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nw 229 Canal Park Drive Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Alison C. Ainsworth/sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation Service 4/22/08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service-ticensee Communications that cause 22 Name and Address of Facility Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 days Physician pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner alzheimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): vision or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à disease 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe res 2 1□ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D34849 MD April 21 2008 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 1645 Liberty MD illiam Jan

Registrar

State

31. Date filed (Month, Day, Year)

2 3 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year 7:00 PM 2000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Imore Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 1 □ M 2 💢 F Months Days Min 20 76 Yrs Director Usual Residence of Deceder Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits event, the Medical Examinar must be nutified at Funeral Director 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No þ 3 ☑ Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Monce. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) (daug ter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MemPar 12008 22. Name and Address of Facility Signature of Funeral Service Licensee Joseph tuneral 22 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Find **Physician** Stave disease or condition resulting in death) nd /Medical Due to (or as a cons vuence of) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 687605 Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) certificate has been signed by the ector, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ÷ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manyfer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 11 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Rasterstum 5 State 31. Date filed (Month, Day, Year) Registrar's Signature APR 23 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
Division or Vital Records, P.O. Box 68760, San Baltimore, Maryland 21215-0036	To the Hospital or Attending Physician: The law requires that the death certificate be executed X S Within 24 hours after death.	Δ =

Funeral Director

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DHMH 17 Rev 1/2001

State

Registrar

5h AKUNMAC 31. Date filed (Month, Day, Year)

APR 23 2008

32. Agistrar's Signature

COLUMBIA 2104

			For State Registrar	Ce	ertificate of Death	R	leg. No.	13163
	Physici	an	Decedent's Name (First, Middle, Last) HELEN LOUISE BARNES			2. Date of Dea Month	th Day Year	3. Time of Death 4:15P M
	/Medic	cal	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		16, 2008 4c. County of Death	
ĺ	Examin	ier	OVERLEA HEALTH & REHABILIT	'ATION	BALTIMORE CITY		N/A	
5,7	Funeral Director		219-26-7600 1 M NDF	(In yrs. last birthday 67 Yrs.			9. Birth	pplace (State or Foreign untry) XYLAND
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or L	ocation ORE CITY			10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28a ist be noti	al Director	10e. Street and Number 901 CHERRY HILL ROAD, APT	. #466	10f. Zip Code 21225		10g. Citizen of What Col	untry?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 W N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- erto Rican, etc.)		
7-CI717	filed within 72 ha Hygiene. Ather than "natu ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) OOL CROSSING GUAR	16b Kind of Business/I BALTIMORE C PUBLIC SCHO	ndustry CITY OOLS	
land	ould be file Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) WOODROW CUNNINGHAM		1	ame (First, Middle, IA SMITH	Maiden Surname)	
, Mar	1 and 2 should Health and Men em 27 is marker other traumatic		19a. Informant's Name/Relationship (Type. Print) GWENDOLYN REESE / DAUGHTER	272	ing Address (Street and Number or F	LTIMORE,	MD 21225	,
parillmore	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 The Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	KING ME		Date 22/08	20c. Location - City or WINDSOR MI	LL, MD
ם מ	permit. Depart Import any Inj		21. Signature of Funcial Service Licensee	Noun	22. Name and Address of Facility F	SHTS AVE.	, BALTIMORE	, MD
	Physician /Medical Examiner		23a. Part Ent he disease or complications that caused shot, or art failure List only one cause in each lin Immediae Cruse (Final disease to ondition resulting in death) Due to (or as a	the death. Do we end e. a consequence of):	nter the mode of dying, such as cardi le Cancinor metosta			Approximate Interval Between Onset and Death
,00,	icate be executed physician and sthe burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):				
O. DOX 00/	certif iding ise as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
cords, r	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions contributing to death bu	it not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to res 2 2 No 3 □ Pro	
ar reco	: The law re cate has bee , page 2 sho	Completed				24a. Was a autop perfo 1 Yes	an 24b. Were au prior to commed? death? 2 No 1 □ Yes	topsy findings available completion of cause of
>	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 27 No Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatio	Oil .	eath (Check only o	ne) lence 6 □Other (Spec	-:
on or	ng fte	-	27. Manner of Death 1	of 28c. Injury at Work? M 1 Yes 2 No	7	now injury occurred	ау)	
21212	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined building, etc			City or Tou		·
	the Hosp hin 24 hou the Fune npletely fil	Medical	29a. Certifier Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/or		ccurred at the time,	date and place, and due	to the cause(s)
	\ \$ \$ \$ \$ \$ \$	2	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year) $4 - 18 - 08$				
			30. Name and address of person who completed cause of de M + HAW 566/-	timore m	21239			

State Registrar 31. Date filed (Month, Day, Year)
APR 2 3 2008

32 degistrar's Signature

			For State Registrar	State o	f Marylan		artment of H		, ,	giene Reg. No. 2	A 8	13121
17	1-1-	9	Decedent's Name (First, Midd	le, Last)			1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Dea	ith	00	3. Time of Death
196	Physici /Medic		JANIE L. BE	THEL					APRIL	20 2	Year OOS	907 AM
	Examin		4a. Facility Name (If not institution	n, give street and nur	nber)		4b. City, Town, or	Location of Death		4c. County	of Death	
			THE UNION MEM					ORE CITY			N/A	
	Funeral Director		5. Social Security Number 218–26–3630	6. Sex 1 □ M 2 X F	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/26/1	, _{Year)} 1925	9. Birthpl Count SOU'I'I	ace (State or Foreign try) CAROLINA
	and w		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	/, Town or Lo	cation				10	Od. Inside City Limits
	Mary -f sho fied a	to	MD N	/A		BAL	TIMORE CI	TY				X∏Yes 2∏No
	r 28a	irec	10e. Street and Number	,		10g. Citizen of W	tizen of What Country?					
	th wit	g le	1040 E. 33RD	STREET, A	18		USA					
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 Ⅸ Widowed 4 □ Divorced	rried Armed Fo	27∏ No /e		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 21 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	e - America k, White, 6 BLA	etc.
21215-0036	within 72 ho ene. than "natu he Medical	Completed by	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1	I-4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired URSING (L	luring most of work	ing	16b. Kind of Bu		lustry
21	he filed within al Hygiene. I other than '	S	12	2		MEDI						
Maryland	2 should be fil and Mental H is marked ott raumatic even	To Be	17. Father's Name (First, Middle FRENCH SMITH	18. Mother's Nam		Maiden Surnam TH CARTE						
	nd 2 sho alth and I 27 is me ir traume		19a. Informant's Name/Relation LORRAINE BROWN		RE, MD 2		Code)					
Baltimore,	e = to		LORRAINE BROWN / DAUGHTER 624 QUEENSGATE ROAD, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 State 624 QUEENSGATE ROAD, 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK 4/25							20c. Location - WINDSOR	•	•
Balti	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service		Dair		2. Name and Addres					
	2		23a. Pay Fer the disease, of short, wheart failure. Lis	or complications that controls one cause on e	aused the d							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CE	KERAL (or as a consequ		WLAR AC	RIDEUT				Onset and Death 4 Day
	Examiner		Sequentially list conditions.	b								
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate occurs. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	uence of):						
8760,	sate be executed the side of the purial-transit	al Exa	resulting in death) Last	C. Due to	(or as a consequ	uence of):						
687	ficate g physi as the	edical		d								
P.O. Box	requires that the death certific een signed by the attending p rould be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live t	tcome pf pregna birth 2 □ Feta nant at time of d own	Ideath 3[⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23d. Dat Mor	e of delive nth	ry Day Year
	w requires that the de been signed by the should be detached	d by Ph	Part II. Other significant condit	ions contributing to d	eath but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to			ee cause of death? ably 4 □Unknown
Records,	slcian : The law rer certificate has bee irector, page 2 shor	omplete								rmed?	death?	psy findings available inpletion of cause of 2 No
Vital	ystcian; is certifica director, p	Be	25. Was case referred to medic examiner?					26. Place of Dea				
7	> 0 0	70	1 ☐ Yes 2 💢 No			ER/Outpatie		4 LI Nursing He	ome 5 Resid	lence 6 □Oth	er (Specif	/)
n c	ng ffel	:uo	27. Manner of Death 1 X Natural 5 ☐ Pendi	ng 28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Worl		28d. Describe h	now injury occurr	ed	
Division or	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification:	1 Kind Natural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No No Year No No No No No No No N									l Route Number,
	Hospital	al Ce	29a. Certifier 1 🗶 Certify	ing Physician: To the	best of my kno	wledge, deal	h occurred at the tin	ne, date and place	, and due to the	cause(s) and ma	ınner as si	tated.
	To the Ho within 24 t To the Fu	Medic	one)		asis of examina ner stated.	ttion and/or ir						
	To Viti	2	29b. Signature and title of certific	e i	-		29c. License			29d. Date signed	_	
	1.		30. Name and address of perso	n who completed caus	MD se of death (Itom	1 23a) (Tun^		438946		APRIL	20	2008
	Ч		Robert B.	FAMINIE	W M	D (Type,	UNION	Manage	IAI H	SPITAL	M	\mathcal{D} .
	Sta	ite	31. Date filed (Month, Day, Yea.	<i>M</i> .	Registrar's Signa		1 12 10/0	1010	57 Spain ('Cu			7
	Regist	ar										

DHMH 17 Rev 1/2001

08-02996 Ernest Peter Bra	ndt	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 13125										
Discourse in	ا	I- For State Registrar 1. Decedent's Name	(First Middle Last)		Cer	tificate of De	ath	13	Reg 2. Date of Death			3. Time of Death
Physicia Physicia ≃ nal Exami	-	Ernest		Brandt J	r				Month I April 17, 20)8 	rear .	1951 hrs
•		4a. Facility Name (if Johns Hopki	not institution, give ns Bayview Me				ty, Town, or Location Itimore	of Death		4c. Cour	ty of Death	
Funeral Director		5. Social Security No. 216 14 45	643 1X	7. Ag м 2 F 83			Under 1 Year If Undonths Days Hou	der 24Hrs. rs Min.	8. Date of Birth October		Foreign	place (State or htBaynesville,
any	-	Usual Residence of 10a. State 1	Decedent 10b. County		10c. City,	Town or Location					T	10d. Inside City Limits
	'n	Maryland	Baltimore		Balt	imore Count	y					1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Num				101	. Zip Code 21234		109	i. Citizen of USA	What Count	ry?
with the is 23a c	ra D	3501 E. Jop 11. Marital Status	opa rioau	12. Was Decedent	Ever in U		cedent of Hispanic O			14. R		an Indian, Black,
death v	Funeral		d 2 Married	Armed Forces	No		pecify Cuban, Mexica		Rican, etc.)	W	hite, etc.	
s after iral", o	ক্র	3 X Widowed		If Yes, Give Year WW or Dates: ly highest grade con			2 X No specification (Given		ork done	Speci	fy: Whit Business/In	
2 hour natu	eted	Elementary/Secon		College (1-4 or			working life. DO NO			iob. rana o	Basinessini	dustry
5-0036 led within 7 Hygiene. other than	dmo	8		N/A		Dispatch S				LaFar		
21 be fi	BeC		o. Brandt,				Lill	ie M.	(First, Middle, M Shankli	n		
MD 21 Id 2 should 1 Ith and Mer m 27 is mar	٩	19a. Informant's Nar Calvin	me/Relationship (Ty L Brandt	/pe, Print)			ress (Street and No te Oak Avenu					
re, n 1 and f Healtl f item er trau		20a. Method of Disp		Pamoval from St		Place of Disposition crematory or other p			Date	20c. Locati	on - City or 1	own, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5	Other Specify:			kwood Cemet	ery April 21		3	Baltim	ore,Mar	/land
Balt permit. Depart Import injury	1	2) 6 gnature of Fur 23a. Part I. Enter the	1 7089	nks		Lassa 7401	and Address of Faci hn Funeral H Belair Road	lome, I Balti	more Mary	1and 2:	1236	Approximate Interval
Physician Medical xaminer	al Examiner	failure. List only Immediate Cause (for condition resultin Sequentially list cor if any, leading to im- seuce. Enter Under (Disease or injury the events resulting in o	y one cause on ea Final disease g in death) anditions, mediate thying Cause nat initiated	ch line. Contact Gunsh Due to (or as a cons Due to (or as a cons Due to (or as a cons	ot Wour	nd of Head nh:						Between Onset and Death
	edic	UNPENDED		AMENDED						1324 Day	te of delivery	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be ex refash. reter: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent past 12 months	?	23c. If yes, outco		2 Fetal o	eath 3 Ecto	pic pregna	ncy	Mon		ay Year
P.O. B es that the d igned by the	by	Part II. Other signif	ficant conditions		th but not	resulting in the unde	rlying cause given in	Part I.				the cause of death?
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed								24a. Was a autop: perfor 1 ✓ Yes	ned?		topsy findings available ompletion of cause of
1 of Vital Rec Jing Physician: The I After this certificate I funeral director, page	a)	25. Was case referr					26.Place of Dea		-			
F Vit Physica r this c	To B	1 🗸 Yes	2 110	lospital: 1 Inpati		ER/Outpatient 3		710.0	g Home 5	Residence		:
on of ding I h. e funer		27. Manner of Deat	n 5 Pending	28a. Date of Inj FOUND:	Үөаг)	28b. Time of Injur FOUND:	1 Yes 2		Subject shot		curred	
Ti Bi	ertification:	2 Accident 3 Suicide 4 Homicide	Investigati Could not determine	be 28e. Place of I	njury - At I	0647 hrs nome, farm, street, fa of residence	ictory, office building		28f. Location (S or Town, S 3501 East Jop	ate)		ral Route Number, City
the Hos hin 24 h the Fur	Medical C	29a. Certifier	Certifying Physici Medical Examiner	an: To the best of r On the basis of exand manner stated	amination	dge, death occurred and/or investigation	at the time, date and in my opinion, death	place, and occurred a	due to the caus	e(s) and ma and place, a	nner as state	ed. e cause(s)
To with To com	Me	29b. Signature and	A 1	3 n	0		O.C.M.E.	er		29d. Date April 18		nth, Day, Year)
5H		30. Name and addr Tasha Gree		completed cause of Assistant Medic			nn Street, Baltir	nore, Mi	D 21201			
	tate	31. Date filed (Mon	(h, Day, Year) PR 2 3 20	32. Registr	ar's Signa	ture			-			
Regis				DOME		ORIGINAL						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month 8:05 PM Lois F. Bourgondien 4/16/2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Crescent Cities Center Riverdale If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days Hours 1 □ M 2 🖾 F Months 91 577-14-6894 3/18/1917 Tenhawa, 0K Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1XIYes 2□No MD Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 4415 38th St. 20722 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2⊠ No 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Edward S. French Annie Peddie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12133 91st Terrace, Summerfield, FL 34491 Edward A. Bourgondien, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/22/2008 Brentwood, MD Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscleratic Cardiovascular Diseas year Due to (or as a consequence of): Sequentially list conditions

Physician /Medical Examiner

and

physician

nse ģ the signed by t

page 2 :

The law requires that the death certificate be exec

or Attending

within 24 hours after death To the Funeral Director: completely filled in by the Hospital

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-trar

Physician/Medical Examiner þ pleted I

c			
23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ctopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day	Year
ns contributing to death but not resulting in the underlying cause given in Part I.			
	c	c	c

To B			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
	25. Was case referred to medical			26. Place of Deat	h (Check only one)				
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Oppital:						
	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation			8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred			
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		treet, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical C		nysician: To the best of my knowledge, dea miner: On the basis of examination and/or and manner stated.							
ž	29b. Signature and title of certifier	2	290	. License number	29d. Date	signed (Month. Dav. Year)			

		ai	iu mannei	stateu.	
29b. Signature and title	of certifier	Ou	1,00	Gua	0

D01852

29d. Date signed (Month, Day, Year) APRIL 19 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4208 Queensbury Rd Hyattsville Mid 20781

State Registrar

31. Date filed (Month, Day, Year) APR 2 3 2008

			State of Maryland / De	partment of Hertificate of L			iene eg. No2 0 0	8 3 2 7
			Registrar 1. Decedent's Name (First, Middle, Last)	Continuate of Dodan			h	3. Time of Death
	Physicia		MARY E.	BENNETT		Month APRIL	19, 2008	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			eath
	LAGIIIII		FOREST HILL HEALTH & REHAB CENTER		FOREST HILL		H	ARFORD
No	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 M 2 🗷 F 86 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 19	1921 Ma	Birthplace (State or Foreign Country) aryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location				10d Incide City Limits
	arylar show	-	,					10d. Inside City Limits 1 ☐ Yes 2 X No
	he M 28a-f otifie	Director	MD Harford Forest	10f. Zip Code		1/	0g. Citizen of What	
	a or ben	급	1632 Michelle Court, Apt. F	21050		''	US	
	leath ns 23 must	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		merican Indian,
0	r iter		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 (XNo	If Yes, specify Cuba		Rican, etc.)		/hite, etc.
003	be filed within 72 hours after death with the Maryland tial Hygliene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	lby	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
ည် ၁	72 h 'natu dical	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupa Give kind of work done of Te. DO NOT use retired	ation during most of worki	ng	16b. Kind of Busine	ess/Industry
7	within 72 ene. than "nai he Medio	ם	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired nemaker	"		Own Hom	
7	be filed valued by the halo be to the test of the test		17. Father's Name (First, Middle, Last)	ICHIAKEL	18. Mother's Name	(First, Middle, N		<u> </u>
and	ld be ental ked o	To Be	Franklin George		Florenc			
>	2 should be and Mental is marked raumatic ev	-		lailing Address (Street				te, Zip Code)
, Mar	12 # Z		Tracy Dove - granddaughter 163	2 Michelle	Court, A	pt. F, I	Forest Hi	11, MD 21050
e,	es 1 al of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 20b. Place of Disposition	isposition (Name of crematory or other place	re)	Date	20c. Location - City	or Town, State
arrimor	Pages ment of I ant: if ite ury or o	- 53	4□Donation 5□Other (Specify) Metro Ci	rematory, I			Baltimore	•
gall	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee Williams	Cremation 299 Frede	ss of Facility 1 Society 2rick Road	of Mary	land, Ind	21228
8			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician	1 1	Immediate Cause (Final disease or condition	enn lu				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of)					
	Examiner	_	Sequentially list conditions, b.					
J	ped list	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury.					
	be executed ician and burial-transit	xan	Cause (Disease of Injury that initiated events resulting in death) Last c Due to (or as a consequence of):	:				
2/PC	cate be executed physician and the burial-transit	dical E	d					
Q	tificate ig physi as the l	ledio						
X Q Q	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy	,		23d. Date of	
П	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	5 ☐ Other (specify)	·		Month	Day Year
ĭ	hat the		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause give	en in Part I	23e. Did tok	hacco use contribut	te to the cause of death?
g,	signe d be d	d by	congestive heart fulre					Probably 4 Unknown
Kecords	v requ	etec				24a. Was a	n 24h Wor	e autopsy findings available
ě	The law ite has b	Completed				autops perforr	sy prior nged? deat	to completion of cause of
VItal	ifficate or, pa		25. Was case referred to medical		26. Place of Deatl		2 No 1 1	Yes 2☐NNo
	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Othe			ence 6 Other (Specify)
n 0r	ng Ph fter th neral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inju				ow injury occurred	
<u> </u>	endir	atic	2 Accident investigation	M 1 🗆	Yes 2 □ No			
UIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (St City or Town	treet and Number o n, State)	r Rural Route Number,
_	pitai ours a erai I filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, or	leath occurred at the tir	ne date and place	and due to the c	ause(s) and manne	er as stated
	e Hos 124 h e Fun letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	or investigation, in my o	pinion, death occur	red at the time, d	late and place, and	due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 between the death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Me	29b. Signature and title of certifier	29c. Licens	e number	2	9d. Date signed (N	fonth, Day, Year)
			Damed 3 D	03:	2257		April 2	1, 2007
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty					· · · · ·
			DAVID DUNN - 615 W. MACPHAIL ROAD	- BEL A	IR, MD.	21014		
	Sta Registr		31. Date filed April Day, 322008 32. Registrar's Signature	arte)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 17, Allan H. Bond 2008 April 10:00PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2 Raylon Drive Apt. Nottingham Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Feb 24, 1931 9. Birthplace (State or Foreign Country) Maryland Hours 1X M 2 ☐ F 77 213-30-7408 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Maryland Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Raylon Drive Apt. F 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Pressman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley F. Bond Ruth Money 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Raylon Drive Apt. F Nottingham, Maryland 21236 Mildred R. Bond, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/18/08 Baltimore, Maryland 21. Signatury of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of): Sequentially list conditions, if any, leading to inflinedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 № No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 ☐ Pending investigation

certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the attending nse for ed by the a signed by t page 2 certificate e Hospital or Attending P 24 hours after death. e Funeral Director: After t After :

Examine Physician/Medical þ Completed Be ျှ Certification: completely filled in by the within 24 hours a Medical

Matural Natural

2 Accident

3 ☐ Suicide

4 Homicide

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Show

d other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at

72

Hygiene.

Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other trainment.

Physician /Medical

Examiner

3altimore, Maryland 21215-0036

O

State Registrar 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of eath (Item 23a) (Type, P/nt)

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

	1- For State of Maryland / De Registrar	epartment of Health Certificate of Death	h	giene UUD	10165	
cian dical	1. Decedent's Name (First, Middle, Last) Naomi Brimoce		2. Date of Deat Month	Day Year	3. Time of Death 3:04/PM	
iner	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore	4b. City, Town, or Location Baltimore		4c. County of Death		
al or	5. Social Security Number 6. Sex 1 M 2	(day) If Under 1 Year If Under Months Days Hours	er 24 Hrs. Min. 8. Date of Birth (Month, Day, 3/3/1913	r, Year) Counti	ace (State or Foreign ry)	
tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Paltimore			10	ld. Inside City Limits	
Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Count	ry?	
To Be Completed by Funeral	1717 Ramblewood Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	21239 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 Yes		USA 14. Race - America Black, White, e ATTICA SpecifyAmeric	tc. N	
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during ma fe. DO NOT use retired) DE Maker	ost of working	16b. Kind of Business/Indo	ustry	
To Be Co	8th Hon 17. Father's Name (First, Middle, Last) William Tatum	18. Mot	ther's Name <i>(First, Middle, i</i> Fie Thigpin			
-	19a. Informant's Name/Relationship (Type. Print) 19b. N Judy Parker/Daughter: 171	Mailing Address (Street and Num 7 Ranclewood Road,	nber or Rural Route Number		Code)	
	IXIBUNAL 2 Cremation 3 Hemoval from State	isposition (Name of crematory or other place) IS Mem. Park		20c. Location - City or Tov Balto., MD		
-	Signature of Funeral Service Licensee	22. Name and Address of Fact 9200 Liberty Road			Balto. Co.	
edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cause) Due to (or as a consequence of the cause) Due to (or as a consequence of the cause)	atosh tall	lest lerc		Onset and Death	
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	ry Day Year	
by	Part II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions.	he underlying cause given in Par	Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow			
Completed	COPE / OSIGN		24a. Was a autop	an 24b. Were autop prior to com death?	osy findings availab inpletion of cause of 2 \square No	
Be C	25. Was case referred to medical examiner? Hospital: Hospital:		ace of Death (Check only or		20110	
ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year)	ne of 28c. Injury at		lence 6 ☐Other (Specify now injury occurred	<u>')</u>	
Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)			Street and Number or Rural vn, State)	Route Number,	
Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, and manner stated.	or investigation, in my opinion, o	death occurred at the time, o	date and place, and due to	the cause(s)	
Z	29b. Signature and title of certifier	29c. License numbe	25	Por 122, 20	Oay, Year)	
tate	30 Name and adduse of person who completed cause of death (Item 23a) (The first Month, Pay Year) 31. Date filed (Month, Pay Year) 32. Registrar's Signature	h Backat 2	so, Owings 1	Mills, MO S	1117	

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene FH C878 4/24/08 Hertificate of Death

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 16:24 PM Margaret Jean Brown 200 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hos Pital n/a Bultimore Bu H more 06 Birthplace (State or Foreign Country) Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, 10–13–1937 5. Social Security Number If Under **Funeral** Year) Months 1 M 2 XF 242-60-8950 70 Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 X Yes 2 □ No Director Baltimore n/a 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 0 21207 4014 Dorchester Road USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status Black White, etc.
African-American permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinar 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Job Coach Health Profession 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jasper Jones Sr. Pocavell Cordino Rosa Bell Gooding ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marcelette J. Lee/Daughter 3827 Elmcroft Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4-18-08 Woodlawn, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Parto. Co. of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Farti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Stage endo metria IV month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner burial-transi Multi system

Due to (or as a consequence of): Organ the attending physician and Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only one)

O. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland /		rtment of H tificate of I		_	giene Reg. No.	008	13131
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath Dav	Year	3. Time of Death
	/Medic	al	IRENE 4a. Facility Name (If not institution, giv	e street and number)	BERI	NSTE		Location of Death	APRIL	17 4c, Cou	Zoo	
	Examin	ler	SINAI HOSPIM		MORE	=	BAZTIA	10RE (CITY		N/A	
	Funeral Director	9	220-12-7130	ex 7. Age ☐ M 2 🔏 F	(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 01/15/	1926	9. Birt	thplace (State or Foreign nuntry) MD
yland	ow at		Usual Residence of Decedent 10a. State 10b. Counfy		10c. City, Tov	wn or Loc	cation					10d. Inside City Limits
e Mar	a-f sh tified	ctor	MD BALTIM	ORE	REIS	STER	STOWN					1 ☐ Yes 2 No
th with th	23a or 28 ust be no	Funeral Director	10e. Street and Number 562 KENNINGTON	ROAD			10f. Zip Code 211	136		10g. Citizen	of What Co USA	ountry?
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.		Vas Decedent of H f Yes, specify Cuba ☐ Yes 212 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, White	encan Indian, e, etc. WHITE
d within 72 ho	ene. than "natu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+		(Give l life. L	ent's Usual Occup kind of work done o OO NOT use retired LERK	ation during most of work)	ing	16b. Kind o		Industry
	Mental Hygiene arked other thai atic event, the N	Be	17. Father's Name (First, Middle, Last		FEDON		LLIKK	18. Mother's Name				CONTTI
should be	marked marked matic e	2	NATHAN 19a. Informant's Name/Relationship (FFRON	h Mailin	a Address (Street	REB and Number or Rur	ECCA		ENSTE	
S 01	ealth and 27 is m er traum	ļ,	HENRY BERNSTEIN					GTON ROAD				. ,
g -			20a. Method of Disposition 1		MOSES	MON	sition (Name of TEFT ORE Place HEBREW	^{e)} 04/18	Date /2008		on - City or	Town, State
permit.	Department of Important: If any injury or once.		21. Signature of Juneral Service Rices	1 Sleme	%i	22	. Name and Addres	ss of Facility S	OL LEVI	NSON 8	BROS	., INC.
			23a. Part1. Enter the disease, or shock, or heart failure. List only	fications that cause on each line	1.							Approximate Interval Between Onset and Death
	ysician /ledical		Immediate Cause (Final disease or condition resulting in death)	a. ACUTE Due to (or as a	Consequence	40 C	MEDIA	- INFA	RCTIO	λ/		4 DAYS
Ex	aminer		Sequentially list conditions by AMPE CEREBROVASMULTA ACCIDENT								4 DA45	
/ petn	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):						
ficate be executed	sician and burial-tra	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
artificate	ng phy.	Medical	IF FEMALE:	- a.						100		
the Hospital or Attending Physician: The law requires that the death certification	been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal deat		Ectopic pregnancy Other (specify)			23d.	Date of del Month	livery Day Year
uires that	signed by	by	Part II. Other significant conditions of HYPOLTO	contributing to death but	not resulting	in the un	derlying cause give	en in Part I.		obacco use o		o the cause of death?
law req	S S	Completed	CARDIOMY	OPATHY					24a. Was		4b. Were at	utopsy findings available completion of cause of
The The	certificate h rector, page		Of Manager of and the modified						perfo 1□ Yes	2 No	death? 1 ☐ Yes	
ysicia	.g :5	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/O	utpatien	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			Other (Sne	cify)
nding Ph	fter th	ition: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day		Time of Injury	28c. Injur Worl		28d. Describe			0.197
al or Atte	I Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injur building, etc.	y - At home, for (Specify)	arm, stre	eet, factory, office		28f. Location (City or To	Street and No wn, State)	umber or Ri	ural Route Number,
ne Hospit	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	ysiclan: To the best of niner: On the basis of and manner stat	examination a	je, death and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as ice, and due	s stated. e to the cause(s)
Tot	To the complete of the complet	M	29b. Signature and title of certifier	i', M	10		29c. Licenso		0			th, Day, Year) 17, 2008
1	V		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, I	SINA!	hospir	TAZ O	F BI	AIR	17, 2008 MORE
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2:3 2	32. Registral	's Signature		ent.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 04/16/2008 James Dominic Clavio М 1655 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's

9. Birthplace (State Country) Cheverly Prince Georges Hospital Center If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Days 87 Director July 6,1920 April 16, 2008 167-18-4768 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Maryland | Prince George's N Yes 2 No Director Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12115 Lerner Place 20715 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≜ Yes 2 □ No Army If Yes, Give Year or Dates:42-1974 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced "natural" Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Colone1 U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paolo Clavio Carmela Migliaccio ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus A. Clavio/Son 12115 Lerner Place, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 □Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 7/7/2008 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 days Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of): **Examiner** Conjestive Heart Failure 6 months Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Dilated Cardiomyopathy 6 months and burial-tra Due to (or as a consequence of) Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure (acute) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Respiratory Failure 24a. Was an page 2 s autopsy perform certificate XXNo Sepsis 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be n 24 hours after des ne Funeral Directo nietely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 016273 08 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6130 Landover Road, Cheverly, Maryland Revathy Murthy

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 3 2008

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

32. Registrar's Signature

08-03015	
Joyce Clark	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oyue Olaik	1-For State Certificate of Death	1313
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time	of Death
Medical Examine	er Joyce Olivia Clark April 18, 2008 Year 110	3 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital 4d. County of Death Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	3. Service of Decedent Age (Mys. Ses Britisher) White Pear Hours Min. 08 05 1942 Foreign Country)	<u> </u>
any		side City Limits
faryland 28a-f show 1 at once.	5 MD Baltimore 1X	Yes 2 No
Maryl r 28a-1 ed at o	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10g. Citizen of What Country? 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Citizen of What Country? 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Race - American India White, etc.	
items items	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc.	an, Black,
firer de		
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36 n 72 h nan "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	0.1
1 withing giene.	15. Decedent's Education (Specify only highest grade completed) Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	Lity
215-0036 be filed within 72 hours a near Hygiene. rked other than "matura ent, the Medical Examin	Leon A. Clark, Se. Goldie Howard	•
D 21 ould the d Mer is mar tic eve	19a. Informant's Name/Relationship (Type, Prilit) 19b. Mailing Address: (Street and Number or Burat Route Number City or Town State Zip Code	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Commised by Funeral Director	Maria L. Miller (Sister) 1713 W. Lexington St., Balto, and 21	
9 - 4	20a. Method of Disposition 20b. Place of Disposition (Name of cemels), Date 20c. Location - City or Town, S Crematory of other place)	
-E -G - E - E - I	4 Donation 5 Other Specify: Thous Memorial 4. 24.08 Oaltomore, (שוו
Balti permit. Departn Import injury	21. Signature of Flineral Service License 22. The and Address Facility Cope Fineral Services (12.1229)	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	ximate Interval
'Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease	een Onset and Death
Adminer	or condition resulting in death) Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·
Ţ.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Cause Enter Inderlying Cause	
My. ^{al} is x		
reate be executed physician and the burial - transit	(0) #	
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be cleath. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burication: To Be Completed by Physician/Medication: To Be Completed by Physician/Medication:	AMENDED #23a, 27, perME, g879 5/30/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
687 certificanding	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
P.O. Box 687 that the death certific ned by the attending p detached for use as th by Physician/	2 Sb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Fetal death 3 Ectopic pregnancy Month Day Month Day 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 23e. Did tobacco use contribute to the cause	
P.O. I so that the gned by the e detache		e of death?
Records, P.C. The law requires that ficate has been signed by space 2 should be deter	1 Yes 2 No 3 Probably 4	✓ Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed	24a. Was an 24b. Were autopsy fin autopsy prior to completic	
tal Reco cian: The law certificate has ector, page 2 s	performed? death? 1	2 No
Vital Rec ysician: The his certificate director, page	o 25. Was case referred to medical 26. Place of Death (Check only one)	
of Ving Physi After this uneral dir.	O 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other;	
on of \ nding Phy th. r: After tt te funeral te	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division ospital or Attending tours after death. neral Director: Aft filled in by the func Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rout	e Number, City
Divided in Illed in I	Suicide 6 Could not be determined (Specify)	
To the III. To the III. To the Force Force Completel	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caused and manner stated.	
● ≥		Year)
	(a(1111) O.C.M.E. April 19, 2008	
	30. Name and address of person who combeted cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	(2. 31. Date filed (Month, Day, Year)	
Registra	0 D D O O O O O O O O O O O O O O O O O	

Registrar

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ician		ne (FIRST, MIdidie, Li	ast)			0-1		APR (:	Day	Year 2008	3. Time of Death
dical niner	Lottie 4a. Facility Name ((If not institution, gi	ive street and nu	umber)		4b. City. Town, o	er Location of Deat			unty of Death	
IIIIIei	- M	Hospit		—	more	Baltin	_	+4		,	
al	5. Social Security N		Sex 1 ☐ M 2 💢 F	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year)	9. Birth	nplace (State or Foreig.
or	220-30-] Usual Residence o	1434		84	Yrs.			08 13	23		NC
	10a. State	10b. County			ity, Town or Lo						10d. Inside City Limits
irector	MD	NA			Balti	nore					1 □XYes 2 □ No
Dire	10e. Street and Nu					10f. Zip Code	1207			of What Cou	*
Funeral Director	401 / Sp	oringda.	12 Was Dec	cedent Ever in U	IS 13			Specify Yes or No		Race - Amer	
		ried 2X Married	Armed Fo	orces?			Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		Black, White,	, etc.
d by	3 Widowed	4 Divorced	If Yes, G Year or D	iive Dates:		I∐Yes 2∏XNo	Specify:		Sp	ecify: B	lack
Completed	(Spe	15. Decedent's E cify only highest gr	Education rade completed))	(Give	dent's Usual Occu kind of work done	during most of wo.	rking	16b. Kind	of Business/II	ndustry
dwo	Elementary/Second 12th qu		College ((1-4or 5+)		00 NOT use retire inistra	*		Johns	Hopk	ins Hosp:
Be C	17. Father's Name							me (First, Middle,			
70 B	Bernard	Whitin	g				Minnie	Pass			
To Be Completed by		lame/Relationship			1	-	and Number or R				
	James La		Cole-				ngdale				
	20a. Method of Dis 1 ☐ Burial 2	sposition Cremation 3 ☐ 5 ☐ Other <i>(Spec</i>	Removal from	State 20b.		sition (Name of natory or other pla		Date		ion - City or T	
aù l	Commence and	15 ☐ Other (Speci uneral Service Lice	-		Woodl	AWN . Name and Addre	4/25	/08	Balt	imore	Co, Md
ouce	V XM	AAAA (SA.	mH			H West ash Ave	. Balti	imore	. Md	21215
	23a. Par 1. Enter t	the disease, or con	mplications that	VVI		500 mas		,			
				caused the dea	ath. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate
n \	I Immediate Cause	art failure. List only (Final	y one cause on e	each line.		40	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
al 👌		art failure. List only (Final	y one cause on a	ardia (or as a conse	c av	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
al er	Immediate Cause dise se or condition realting in death)	art failure. List only (Final on	a. Due to	each line. Rdia (or as a conse	quence of):	40		c or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 Nour 7 days
al er	Immeriate Cause diserse or condition regulating in death) Sequentially list conif and leading to include a cause. Enter Under Cause (Disease or	art failure. List only (Final on on onditions, namediate erlying r injury	a. Due to	each line. Rdia (or as a conse	quence of):	rest		c or respiratory a	rrest,		1 hour
al 👌	Immeriate Cause diserse or condition reculting in death) Sequentially list condition to improve the cause. Enter Under	art failure. List only (Final on anditions, nmediate eritying r injury	a. Due to b. Due to	each line. Rdia (or as a conse	quence of):	rest		c or respiratory a	rrest,		1 hour
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		1- State Registrar amend #20b Per DH g878 4/23¢	Officate of Death	Reg.	. No.	2 Time of Death		
Physic	an	1. Decedent's Name (First, Middle, Last)		Month 4/16/	Day Year	3. Time of Death 9:06 P M		
/Medi Examir		Virginia Aylette Crotts 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4/10/	4c. County of Death			
Exami	iei	Washington Adventist	Takoma Park	}.	Montgomer	v		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Ye	Q Righ	place (State or Foreign untry)		
Director		577-07-3403 1□ M 2⊠ F 95 Yrs.	INOTITIS Days Hours IVIIII.	7/19/19	12 Wash	nington, D.C		
and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d. Inside City Limits		
f sho	ō	MD Prince George's	College Park			1⊠Yes 2 No		
tal Hygiene. Ital Hygiene. dother than "natural", or itams 23a or 28a-f show event, the Modical Examitrer mat be notified at	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?		
	Oi	9539 Rhode Island Avenue	20740		U.S	Δ		
E SIL	Funerai		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,		
or its	/Fu	1 Never Married 2 Married 1 Tyes 2 No	1 ☐ Yes 2 ☒ No Specify:	riodri, oto.)	Specific			
urai	d by	3 X Widowed 4 Divorced Year or Dates:		1		White		
1.0	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/li	noustry		
than the	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home	2		
other	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		 -		
Menta rked fice	To E	Alduce Craig Brent	Isabelle	G. Ander	son			
permit. rages : and 2 should be fried writing important: If item 27 is marked other than any njury or other traumatic event, Item and once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zi	ip Code)		
and			Klingle Rd., Wash	1000				
if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition	position (Name of ematory or other place) 4/24/	2008 200	c. Location - City or T	Town, State		
tant: jury			itan Crematory		Alexandri	a, VA		
Departr Importr any nj			22. Name and Address of Facility			imore Avenue		
10240		23a. Part 1. Enter the disease, or our plications that ceused the death. Do not e	asch's Funeral Home			Le, MD 20781 Approximate		
ate be executed hysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (ot as a consequence of): c. Due to (or as a consequence of): d.	illation					
ing far requires that the death centificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	very Day Year		
detact	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underwing cause given in Part I	23e Did tobac	co use contribute to	the cause of death?		
s been signed t	ed by		andonying odoso givon in that i.		2 □ No 3 □ Pro			
has ber je 2 sho	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of		
ate ha	E O			performed	d? death?	2 No		
certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Deatl	h (Check only one)				
this or	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati			e 6 Other (Spec	ify)		
After 1 funera	Certification:	27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred			
r death. actor: After this certifica by the funeral director, p	icat	2 Accident investigation 3 Suicide 6 Could not be determined and suicide 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Logation (Street	et and Number or Rui	m I Pouta Alumba s		
Dirac in by	ertif	4 Homicide determined 288. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, S		ar nobte rydmber,		
within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
o the o	Med	one) and manner stated. 29b. Signature and title \$\phi\text{certifier}\$	29c. License number	29d.	. Date signed (Month	. Day, Year)		
within 24 hours a To the Funeral I completely tilled		1 Clame MG	D63839	1.	117/08			
1		30. Name and address of person who completed cause of death (Item 23a) (Typi		1 ale	1111			
9		Padma Chirumamilla 7600 Caroll Ave	Takoma Park, MD	20912	•			
Sta Regist		31. Date filed (Month, Day, Year) APR 2 3 2008 32 Registrar's Signature	ale					
negist	al	TAK 79 TAMO MARINE >						

DHMH 17 Rev 1/2001

08-03000 Jo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 13137

hn C Cifolilli	State of Maryland / Department of 1-For State Certificate of		Reg. No.	2000 10.0
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day April 17, 2008	3. Time of Death Year 2008 hrs
erral Examiner		4b. City, Town, or Location of Death		ounty of Death
).	783 Harmony Avenue	Arnold		ne Arundel
Funeral Director	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/ July 7, 19	90 Sirthplace (Stata or Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits
≜	MD Anne Arundel Arnold			1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Numbar	10f. Zip Code	10g. Citizen	n of What Country?
ith the Maryle s 23a or 28a-f s notified at o	783 Harmony Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21012 as Decedent of Hispanic Origin? (Sp		I. Race - American Indian, Black,
r death with or items 23	1 XNever Married 2 Married Armed Forces? 1 Yes 2 X No	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
safter d	3 Widowed 4 Divorced in res, one rear	Yes 2 X No specify:		d of Business/Industry
72 hours n "natur at Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder 16a. Deceder	nt's Usual Occupation (Give kind of w nost of working life. DO NOT use reti	red)	d of business/industry
vithin 72 enc. Pr. than Medical	Labore			struction
11215-0036 Id be filed within 72 hours a fontal Hygiene. narked other than "natura event, the Medical Examit	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Su Ann Cifolill	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	40h Mailin	ng Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip Code)
MD rd 2 sho lith and m 27 is aumati	Patricia Frederick/mother 1216	Hilltop Drive Ani	napolis, MD	21409 cation - City or Town, State
Ore, ges I am of Hea If iter	crematory or o			sville, MD
Baltimore, permit, Pages I an Department of He. Important: If ite injury or other tr	4 Donation 5 Other Specify:	Name and Address of Facility ing Home Cremation		
Ba Perm Depa Imp	1 WOND, Y THO, WING MO1251 Be	verly L. Heckroti	te. P.A. Cla	arksville, MD 21029
Physician Vedical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	or respiratory arrest, shock	k, or heart Approximate Interval Between Onset and Death
.kaminer	Immediate Cause (Final disease or condition resulting in death) a. Aortic dissection Due to (or as a consequence of):			
	Sequentially list conditions, b.			
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
Exa.	events resulting in death) Last d.			
te be executed ysician and burial - transit	UNPENDED ##50FFII,27,perME,g879,	5/7/08 TT		
Box 68760, can certificate be the attending physicil of for use as the buring the section (Macdian).	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregn		Date of delivery Month Day Year
x 68 th certif	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
that the death certificat the death certificat ned by the attending ph detached for use as the by the Devicion M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
P.O es that igned be detac			1 Yes 2	No 3 Probably 4 Unknown
ords, P w requires t as been sign should be o			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Records, P.(ng Physician: The law requires tha ther this certificate has been signed meral director, page 2 should be det			performed? 1 ✓ Yes 2 No	death? 1 Yes 2 No
ician: The certificate rector, page		26.Place of Death (Checkent 3 DOA Other Nurs		nce 6 🗸 Other: Scene
n of Vi	1 V Yes 2 No 28a Date of Injury 28b. Time of		28d. Describe how injur	
tending eath. tor: Al	1 X Natural 5 Pending (Month, Day, Tear) 2 Accident Investigation	1 Yes 2 No		
Division ospital or Attending spital or Attending lours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify)	reet, factory, office building, etc.	28f. Location (Street ar or Town, State)	nd Number or Rural Route Number, City
Tospita Tospita Toppita		curred at the time, date and place, ar	Indidue to the cause(s) and	d manner as stated.
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred	at the time, date and pla	ice, and due to the cause(s)
F S F 5	29b. Signature and Me of certifier	29c. License number O.C.M.E.		Date signed (Month, Day, Year)
0	30. Nagle and address of person who completed cause of death (Item 23a)	0.0.0		
.0	Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore, Mi	O 21201	
Sta	ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	refle)		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 3:15 A M **Physician** 2008 April 20 Elizabeth Curbeam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Months Min 1 □ M 2 🖔 F 79 4-18-1929 S.C. Director 249-60-8349 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location t be notified at 10h County 10a. State XXYes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 23a or 2 USA 21213 1677 Cliftview Avenue **Examiner** must Funeral within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes **¾☐x**No If Yes, Give 1 ☐ Never Married 2X Married Specify: Black 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 "natural", or by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) N/A Housewife Home 12th grade permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the any injury or other traumatic event, the secont is the secont in the secont is the secont in the secont is the secont in the second in the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Holley Rev. David Chisolm 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband Baltimore, MD 21213 1677 Cliftview Avenue James B. Curbeam, Sr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4-28-2008 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) week neumo **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t I be deta 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 UNO 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Two 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No nours after death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours aft

To the Funeral D

completely filled in Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

State Registrar

29b. Signature and title of certifier

relanie

Year)

2 3 2008

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERRIOR

7. Registrar's Signature

DHMH 17 Rev 1/2001

29c, License number

At24 38946

M.D. Union Memori Hospital

29d. Date signed (Month, Day, Year)

April 20, 2008

		•	For State of Ma State Registrar	ryland / Depa <i>Cer</i>	rtment of He tificate of D			giene Reg. No. 2	08	13139
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	Examin	er	4a. Facility Name (If not institution, give street and number)		-	or Location of Death 4c. County of Death				
			Vantage House	(In the second s	Columb	If Under 24 Hrs.	8. Date of Birt	Howa		lace (Otate - Fi
	Funeral		1□M 2X)F	(In yrs. last birthday) 7 Yrs.	Months Days	Hours Min.	(Month Day	v Year)	Count Miss	lace (State or Foreign try)
Miles Disease	Director	-	225-52-7623 Superior	/			Jan. 7	, 1911	LITSS	Ouri
	land ow at			10c. City, Town or Loc	cation				10	0d. Inside City Limits
	Many Fied	ţ	Maryland Howard	Columbia	L					1 □ Yes 2 XNo
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of \	What Coun	try?
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٥	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No. If Yes. Give) 1	☐Yes 2XXNo	Specify:	, , , , , , , , , , , , , , , , , , , ,		v: Whi	
5-0036	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:							
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\leq	should ind Men marke umatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a			er, City or Town,	State, Zip	Code)
Mar	and 2 sealth ar		Carol Conover Daughter	205 E	ast 78th	Street,	New Yor	k, NY	10021	·
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altimore,	Pages nent of I nrt: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	ematory,		9/2008	Ralti	mora	Maryland
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1	res that i signed by be detar		Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	he cause of death?
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Division	nding F. th. The After a funera	tiol	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury		Yes 2 □ No				
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Examiner: On the basis of							
	the H iin 24 the F the F	Medical	one) and manner sta			·				
	To To	2	29b. Signature and title of certifier		29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
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	0,		30. Name and address of person who completed cause of de		•	Alo A.	1	11 -		1 01 - 0
			31. Date filed (Month, Day, Year) Registra	Con Williams Signature	nivea	eter 40	carpi	THURY OF	, ul	1 21228
	Sta Registr		APR 2.3 2008	a s signature	while I					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 17, 2008 Physician 9:00P BARBARA BEACHAM CUSHING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1529 Bolton Street Baltimore None 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y April 14, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XX Months 212-24-8731 83 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at XXXYes 2□No Directo Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1529 Bolton Street 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 □ Yes 💥 No White Specify Completed by 3 Widowed 4 Divorced If item 27 is marked other than "natural", or other traumatic event, the Medical Exa 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Francis Beacham Grace Busey မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Osborn Cushing 1529 Bolton Street Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Removal from State Druid Ridge Cemetery Pikesville, Maryland April 24, 2008 □Donation 5 □ Other (nature of Funer 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, com shock, or heart failure. List only s that caused the death. Do not enter the pode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death complicatio Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence off Examine burial-trar Due to (or as a consequence of) Box 68760. attending physician the death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐ Yes 2☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 8 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural (Month, Day Year) 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatyne and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory L Walker MD 3333 North Calvert Street Suite 540 Baltimore, MD 21218 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#20b, perFH, 0878, 4430/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:11 PMM William Decker 2008 April 17, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) Days Min Months 1 M M 2 □ F 57 DC 579-68-1446 08/15/1950 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ¥Yes 2 No Director MD Calvert Chesapeake Beach 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20732-United States 8420 D Street Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1970 - 72 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Utility Company** Elementary/Secondary (0-12) College (1-4or 5+) Lineman 7 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Evelyn Rutherford William Barton Decker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Murphy/Daughter 1980 Crossroad School Rd. Hedgesville, WV 25427-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April Aug 19 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Rapp Funeral & Cremation Services m00382 Tipled Lohmann 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardionyopas disease or condition resulting in death) Dilated Due to (or as a consequence of) neumon. Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

signed by the atter P.O. Division or Vital Records, cate has been signated bage 2 should b this certificate funeral director, After t al or Attending I after death. neral Director; / To the Hospital within 24 hours at To the Funeral C

Funeral

Director

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7 Is marked other than "natural", or items 238 traumatic event, the Medical Examiner must

oe filed within 7. al Hygiene.

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permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 Is
any Injury or other trau

Physician

/Medical

Examiner

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certificate be executed

Box 68760,

1 and 2 should be

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

X

State Registrar

FE. m.O SUNG 31. Date filed (Month, Day,

29b. Signature and title of certifie

7901

Takoma

29c. License number

29d. Date signed (Month, Day, Year) April 18, 2008

Paric

20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayole

Registrar's Signature

APR 23 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene; Certificate of Death 2. Date of Death 3. Time of Death edent's Name (First, Middle, Last, Month **Physician** 540 PM 2008 /Medical County of Deatt 4b. City, Town, or Location of Death acility Name (If not institution, give street and number Examiner DMMunit 8. Date of Birth (Month, Day) **Funeral** Days Hours Min. 216-36-068 Months 1**X** M 2∏ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Mes 2 No MD Directo toward olumbia 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21045 ane "natural", or items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Blac 3 Widowed 4 Divorced Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life DO NQT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) acher Tyrs 18. Mother's Name (First, Middle, Maiden Surname) Be 9ra Ce ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) olumbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 ☐ Cremation larksville, 5 ☐ Other (Specify) ne Funeral Services 21. Signature of Funeral Service L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** emon disease or condition resulting in death) /Medical Due to (or an a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ohysician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contri uting to death but not resulting in the underlying cause given in Part i. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autops 1 r: After this certifica e funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl Ine Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 2 ☐ ER/Outpatient 3 ☐ DOA Inpatient 1 🗌 Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 061552 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor

State Registrar

2 3 2008 DHMH 17 Rev 1/2001

Kevin K.

31. Date filed (Month, Day, Year)

8118 32 Registrar's Signature

MD

Good

Luck Rd.

Carham

			1 - For State Registrar	state of Maryland	d / Depa	artment			ntal Hygie	•	13143	
,	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give stree Washington Advent:			-	own, or Location o		Date of Death Month	Day / 200 4c. County of Dea	ath	
I	Funeral Director		5. Social Security Number 577-06-6412 Sex Multiple Security Number 578-06-6412	7. Age (In yrs. la 39	st birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, Y	(ear) 9. Bi (68 Cos	rthplace (State or Foreign Country) Sta Rica	
Maryland 2	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: If tiem 27 is marked other than "netural; or items 23s or 28s-f show int: If tiem 27 is marked other than "netural; or items 25s or 28s-f show int or other traumatic event, the Mudical Exercise must be notified at	ector	10a. State 10b. County DC		Town or Lo	on					10d. Inside City Limits 1 Yes 2 □ No	
		Funeral Director	405 Tenth Street, N. E. #101			20002				Costa R:		
		þ	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1		int of Hispanic Original Cuban, Mexican No Specify:			14. Race - Am Black, Wh Specify:		
		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Special Ed College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Program				7	16b. Kind of Business/Industry Day Program		
		To Be C	17. Father's Name (First, Middle, Last) Carlos Duran			18. Mother's Name (First, Middle, Maid Teresa Briceno				iden Sumame)		
			19a. Informant's Name/Relationship (Type, Teresa Briceno	Print) (Mother)			Street and Number n Street			City or Town, State, W a shi n gte	Zip Code) on, DC 20002	
nore,			20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Rem	oval from State	ace of Dispo metery, cren	natory or oth	er place)	Dat 04/26/		oc. Location - City o		
Baltimore,	permit. Pag Depertment Important: eny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Baron CC	22	. Name and	Address of Facilit	₩. H.	. Bacon	Funeral 1	Home, Inc. , DC 20010	
P.O. Box 68/60,	the death certificate be executed When the attending physicien end ached for use as the burial-transit The death certificate be executed The death certificate be executed by the death certificate by the death c	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
		by Physician/Medical E	d						elivery Day Year			
	wrequires that the d been signed by the should be detached	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detected.	Completed	Dysphapia			a p			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
6		ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury									
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, street, factory, office 28f.				f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical	29a. Certifier (CHRCK ONLY ONE) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
			29b. Signature and title of certifier Do 1852					52	1	29d. Date signed (Month, Day, Year)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								, (HyaVEVILY MD20781			
	Sta Registi		31. Date filed (Month, Pay Year) APR 23 2008	32. Registrar's Signat	US CYC	ren	sbury /C	el r	1490	PUVIT	MUDICI	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0030 M MAND 6 OX /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours Min Director 175-18-4523 89 JUN 12 1918 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Coxswain Way, #204 21401 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Manufacturing rdment of Health and Mental Hy rtant: If Item 27 is marked other and marked other and the mar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Desire Drugmand ပ Grace Corbett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen J. Drugmand - wife 803 Coxswain Way, #204, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department or Important: If any injury or Metro Crematory, Inc. 4/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a possequence of): ecu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the o 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, funeral director, page 2 should be Be Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 certificate Division of Vital 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral D Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar Name and address of person

Date filed (Month, Day, APR 2

DHMH 17 Rev 1/2001

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who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dat **Physician** 0:00PM /Medical Facility Name (If not institution, give street and number, 4h City Town, or Location of Death 4c. County of Death Examiner Randallstown EMMONE Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗗 F Months Days Hours Min 213-32-0092 Director Jan. 17. 1933 N. Carolina Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c City Town or Location 10a State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland N/A 1 X Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3306 Elgin Avenue Funeral 21216 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 SpecifyBlack If Yes, Give Year or Dates: 1 □Yes 2√ No Specify. <u></u> 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Je filed wit.
**I Hygiene.
** than "r (Give kind of work done during most of working life. DO NOT use retired) Spring Grove State College (1-4or 5+) Years Elementary/Secondary (0-12) Nursing Assistant Hospital 12 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Dennis Furrs Willie Gaston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Morris/ Daughter Health em 27 i 2629 W. Lafayette Avenue Baltimore, Maryland Baltimore, Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4/21/08 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Egineral Service-5240 Reisterstown Rd Baltimore, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart allure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-transi Exami Due to (or as a consequence of): Box 68760. nding physician use as the buria Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ SONTO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 2 10 certificate a 1 □Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Division of 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 □Yes 2 □No death. To the Hospital or Attend within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person tho completed cause of

Registrar

State

31. Date filed (Month, Day, Year)

2 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5:25 AM 2008 Reginald D torgan Apri 21 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours XXM 2□F 212-66-6445 38 04-20-1970 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No MD Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 920 Niagra Court 21227 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify. 3 Widowed 4X Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald D. Forgan Sharon Happel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Forgan - Mother St. Denis, 1803 Main Street. Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April XXBuriat 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 24, 2008 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Sign ture of Funeral Service L M00053 auch 1 7250 Wash. Blvd., Elkridge, MD 21075 MMP, Inc., Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alcoholic Cirrnosis disease or condition resulting in death) Due to (or as a consequence of): Brain nerniation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am jujury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and for use as the burial-transit After this certificate Physician: after death.

I Director: After this d in by the funeral d

Division or Vital Records, P.O. Box 68760,

or Attending

Hospital 24 hours a

within 2

Il Examiner Certification: To

resulting in death) Last	Due to (or as a consequence of): ■d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Ch	eck only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(<i>Month, Day Year</i>) Injury Work? In M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of injury - At nome, farm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, and o miner: On the basis of examination and/or investigation, in my opinion, death occurred a	

29c. License number

AU4176435N16686

29d. Date signed (Month, Day, Year)

April

21

2008

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State Registrar

filled in by

Medical

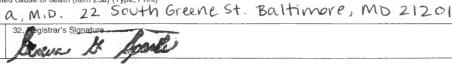
Penali Noticewala, M.D.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 23 2008

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TITEM/1 per HVS 2878 4/23/08 VS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Geraghty Marie **Physician** 140 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Examiner WOG D Year Days If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Months 220 - 24 - 0203 Usual Residence of Decedent Director 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 1 1 No Funeral Director 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number 025 2 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tho 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; if item 27 is marked other than "a may Injury or other traumatic event, the Magnon. Elementary/Secondary (0-12) College (1-4or 5+) +OUSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NUUOOD ALTO. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARTOFMARI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknow ig to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown page 2 should Be Completed been 8 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an has autopsy certificate 1 ☐ Yes After this certific funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 2 NO 1 ☐ Yes Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Teath 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of c 29d. Date signed (Month, Day d cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State APR 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/14/2008 (aka Elizabeth Anne Lartigue) <u>7:0</u>7 P™ Elizabeth Anne Garrison 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Holy Cross Rehabilation & Nursing Center Montgomery Burtonsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖾 F 78 7/9/1929 Maryland 216-22**-**2223 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 MYes 2□No Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21046 U.S.A. 6505 Belleview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 2⊠ No 1 ☐ Yes 2 No Specify. Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Art Display Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne Waters Luis Granados 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Buckley, Daughter 6505 Belleview Dr., Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/23/2008 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 17 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, reading to ministrate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence off that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown (Multiple) 24a. Was an Were autopsy findings available prior to completion of cause of

Physician /Medical Examiner Examiner

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25. Was case referred to medical examiner?	20.1 Made of Bodal (Chook only one)									
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, stree	t, facto	ory, office	28i. Location (Street and Number or Rural Route Number, City or Town, State)					

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and attle of certifier

120053337

29c. License number

29d. Date signed (Month, Dav. Year) 4-21-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith Avenue Sude 203 Baltimore, Md 21209 Secry

State Registrar

31. Date filed (Month, Day, Year) APR 23 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 14 Physician 2008 MARY TERESA GALBRAITH 8:05a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE VILLA BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/14/1923 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F TENN. 224-68-9795 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6806 BELLONA AVE 21212 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 4YRS Elementary/Secondary (0-12) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK GALBRAITH CARRIE SPENCE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER JODENE (POA) 3725 ELLERSLIE AVE BALTO., MD. 21218. Health a or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CLARE COURT CONVENT 04/18/08 BALTO CITY, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service L 22. Name and Address of Facility W. JENKINS & SONS YORK RD MONKTON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 14/ disease or condition resulting in death) CCrebrovaszykar accident /Medical Due to (or as a consequence of) Examiner igpetes mellitys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical (F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 9∏Unknown ed by th 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. <u>م</u> 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate ha 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital within 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2008 Physician 155 AM BERNARD GUILFORD toril /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE Birthplace (State or Foreign Country) MD Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/26/1929 7. Age (In vrs. last birthday) **Funeral** 1 1 M 2 □ F Days Hours 215-24-1838 78 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location 28a-f show 1 ☐ Yes 2 No Completed by Funeral Director BALTIMORE RANDALLSTOWN the 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examination is been any Injury or other traumatic event, the Medical Examination is some. 5412 OLD COURT ROAD 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 1 M Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE If Yes, Give Year or Dates: Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TRUCK DRIVER TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GUILFORD** BESSIE ROBOFSKY ပ္ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY K. SULLIVAN / ATTORNEY 10 N. CALVERT ST., #200, BALTIMORE, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 04/22/2008 REISTERSTOWN, MD _ 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. uneral rvice Lio 21. Signitud 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Inter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Immediate Cause (Final **Physician** TERMINAL GASTROINTESTINAL BLEEDING resulting in death) /Medical Due to (or as a consequence of): **Examiner** MULTISYSTEM OXEAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of highly that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii

State Registrar

lerce 31. Date filed (Month, Day, Year) APR 23 2008

29b. Signature and title of certifier

Deborah

MAIN STREE 32. Pegistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

REISTENSTOWN, MP

29d. Date signed (Month, Day, Year)

20th 2008

08-02906 Annie Hall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 | 3|5|

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			For State Registrar	State of Maryland		artment o <i>rtificate d</i>			giene Reg. No. 🥤	nne	13152			
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death!			
	Physicia /Medic	-	Karl Gerhardt Haga	n				April :	-		2300 ^M			
ì	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Death		4c. Co	ounty of Death				
			Holy Cross Hospita				Spring	0.5.1.1.15		ntgomer				
6	Funeral		5. Social Security Number 6. Se	YM OFF	st birthday) Yrs.	Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Bir (Month, Da	v. Year)	Coui				
18°.	Director		578-30-7324	80	115.			02/06/2	L928_	Wasn	ington, D.C.			
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside City Limits			
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	the tage 28a-	Director	Maryland Prince G	eorge's Bowi	.e	10f. Zip Co	de		10g. Citize	n of What Cou	ntry?			
	with 3a or		3819 Irongate Lane			2	0715		Į	J.S.A.				
	be filed within 72 hours after death with the Maryland ntal Hygiene. Indicate than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	3. 13.	Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No	14	. Race - Ameri Black, White,				
0	or iter		1XXXNever Married 2 ☐ Married	Armed Forces? MXYes 2 □ No USN If Yes, Give	AVY	ir res, specily 1 ∐ Yes 2.5X		nican, etc.)			ite			
21215-0036	ral", c	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 45-19	47	10 163 212	ito opcony.							
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2	led w lygier her th	ပ္ပ	-12- 17. Father's Name (<i>First, Middle, Last</i>)		Prin	ter	18. Mother's Name	e (First Middle	-	enter's	OHIOH			
u	be fi	Be	•	C zo			Mary Doi	•						
$\frac{8}{5}$	should be tand Mental Is marked o	2	Peter James Hagan, 19a, Informant's Name/Relationship (7)		10h Mailir	na Address /St	reet and Number or Rui				n Code)			
Maryland	12 sho th and 7 Is m traum		Thomas P. Hagan	ype. rumij			vue Lane, S							
	ges 1 and 2 should be filed it of Health and Mental Hygi If item 27 Is marked other or other traumatic event, t		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name (of i	Date		ation - City or T				
altimore,	Pages nent of int: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Mou		matory or othe ivet	rpiace)	10000	TT 1	•	D. C.			
	artme ortani Injuri		21. Signature of Funeral Service Licens		Cemet	ery 2. Name and A	ddress of Facility Ro	/2008	wasn. Evai	ington, as Fune	ral Home			
B	permit. Page Department Important: II any Injury o		· au 1				nnapolis Ro							
			23a Part1 Enter the disease, or comp	lications that caused the death						-	Approximate Interval Between			
	Physician ¹		Immediate Cause (Final											
	/Medical		disease or condition resulting in death)	a. Supraventric		таспуса	ruia							
	Examiner			Pulmonary Ed	lema									
		Jer	Sequentially list conditions,	Due to (or sele consequ										
	outed id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Colorectal	Fistu	1a								
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68760,	icate be executed physician and the burial-transit	edical		d										
_		Med	IF FEMALE:											
ရွိ	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 Live birth 2 Feta	Ideath 3	Ectopic preg			23	3d. Date of deli Month	very Day Year			
<u>.</u>	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Other (speci	TY)							
Records, P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	ınderlying caus	e given in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?			
Ŝ	ires t signe	by	T and in the state of the state	y -	Ü		•	1 🗆	Yes 2□	No 3□Pro	bably 4 XUnknown			
Š	aw require s been sig s should b	Completed						24a. Wa	san	24h Were au	topsy findings available			
36	ne law has l	Idm						auto	opsy formed? 2 \(\overline{\Omega}\) No	prior to death?	ompletion of cause of			
a			os W				OC Disease A Dec			1 ☐ Yes	21 No			
₹	Physician: The lav r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 [XNo	Hospital: 1 X Inpatient 2 □	EB/Outpatie	nt 3ETDOA	26. Place of Dea	ome 5□Res		□Other (Sae	nific)			
ō	Physic ruthis aral di	-T	27. Manner of Death	28a. Date of Injury	28b. Time o		Injury at Work?	28d. Describe			,			
on	ding h. Afte fune	tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No							
Division or Vital	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	20e. Place of injury - At the	me, farm, st	reet, factory, o	ffice	28f. Location	(Street and own, State)	Number or Ru	ral Route Number,			
\leq	al or after after I Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	у)			City Of Th	JWII, Glale)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 X ertifying Ph	ysician: To the best of my kno niner: On the basis of examina	wledge, dea	th occurred at	the time, date and place	e, and due to th	e cause(s)	and manner as	stated.			
	ne Ho n 24 l ne Fu	Medical	(Check only 2 Medical Exar	and manner stated.	mon and/or i		my opinion, death occu	Ted at the time						
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ž	29b. Signature and title of certifier	/-			icense number			signed <i>(Monti</i> /2008	n, Day, Year)			
	10+		1. 10				65305		7/41	, 2000				
,	iva		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type	, Print)	1 C:1	or Cari	no M	arv1 ond	1			
	I V		Dr. Nabila Khan		Ly Cro	ss Hos	oital, Silv	er shrr	ing, ri	ar y ranc				
	Sta Regist		31. Date filed (Month, Day, Year) APR 23 20	32 Registrar's Signa	The Age	DOME!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 14, 2008 ar 4:07 PM **Physician** JAMES C. HILL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAI HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3/05/1938 9. Birthplace (State or Foreign 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days FLORIDA 262-52-7594 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No BALTIMORE CITY N/A MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4809 NURTON AVENUE 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2Ď No if Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **MAINTENANCE** GROUNDS KEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CORINE DUNBAR ROBERT J HILL ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VIVIAN P. MCDUFFIE / DAUGHTER 24 TORLINA COURT, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY 4/19/2008 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Euneral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Approximate Interval Between Onset and Death the disease, or complications that caused the death. te Juse (Final one hour **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 | Yes 2 | No 3 | robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1□ Yes I or Attending Physician: after death.
Director: After this certificat 25. Was case referred to nedical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2-ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058860 APRIL 17, 2008 3333 N. CALVERT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAWN DHILLON MD 139 LTD, MD 21218 SUITE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

08-03102 Kevin Hoang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 13154

			For State				Certific	ate of	Death					Reg. No			O. Time of Death
Phy	ysicia		. Decedent's Name (First, I	liddle,Las	t)								. Date of Dea Month	Day	Year		3. Time of Death 1341 hrs
	xamir	er	Kevin Hoan	J									April 21,		c. County of	E Dooth	
		4	a. Facility Name (if not inst			umber)		4	b. City, Tow		ocation of	Death			Howard	Death	'
			Howard County G	eneral H	lospital				Columb		S	0.411	Data of B			Q Rie	thplace (State or
Fun	eral	ŧ	Social Security Number	6. Se	ex	7. Age (In yrs. last bi	rthday)	If Under	1 Year Days	If Under Hours	Min.				Foreid	an L
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	any	Ţ	10a. State 10b. Co	ınty		10	c. City, Tow	n or Locati	on								1 Yes 2 X No
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ie Ma	or 28	Director	6156 Quiet T	imes					21	045				U	nited	Sta	ates
节	or items 23a or 28a-f sho must be notified at once.		11. Manital Status		12. Was De	ecedent Ev	ver in U.S.	13. Wa	s Decedent	of Hisp	anic Origi	in? (Spe	cify Yes or N	No-	14. Race White		rican Indian, Black,
ath w	item:	E I	1 Never Married 2	Married	Armed I	Forces?	X No	If Y	es, specify	Cuban,	Mexican,	Puerto F	kican, etc.)		AAIIIG		:
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-00 d with	ther M	녌	17. Father's Name (First, N	iddle, Las	1)					1	8.Mother	s Name	(First, Middle	e, Maide	en Surname)	
215 e file	ked o	8	Luyen Hoang								Giad	o K	guyen				
21.2 Palle 15	mar ic ev	힏	19a. Informant's Name/Rel	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hoviene	27 is		Thi Hoang,	Broth	ner							ue,	Date				or Town, State
e,	item		20a. Method of Disposition 1 Burial 2 Cre		V Domovol	from Stat		e of Dispo: natory or of	sition (Name ther place)	e or cen	netery,						
nor ages	othe					Irom State	" Choi		eral E					1			hia, PA
Baltimore, permit. Pages 1 at	Department of freatiff and invental riggione. Important: If item 27 is marked other th injury or other traumatic event, the Med	1	4 Donation 5, Other Specify: 21 Signature of Funeral Service Licensee M01113 22 Name and Address of Facility Choi Funeral Home, 1 247 N. 12th Street, Philadelphia, Phil										Inc.				
Bern	ii ii g	1	MINK	6													
hys	ician	\neg	23a. Part I. Enter the disea	se, or con	plications that	t caused t	he death. Do	not enter	the mode of	dying,	such as c	ardiac or	respiratory	arrest,	shock, or he	eart	Approximate Interval Between Onset and
	dical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Death Death Death Death Death Due to (or as a consequence of): Due to (or as a consequence of):														
_xan	niner																
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the d	signed by the I be detached f	Physician	Part II. Other significant	condition	s contributin	g to death	but not resu	liting in the	underlying	cause	given in P	art I.					to the cause of death?
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SOTC BW FE	has be	ള											P	erforme		death	1?
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Division of Vital Records, P.O. Box 68' the Hospital or Attending Physician: The law requires that the death certiff	After this certificate has been funeral director, page 2 should	B B	25. Was case referred to examiner?	medical	Hospital:	7	nt 2 🗸 E	D/O. de etio		26.PI80 IOA	Other ₄		ng Home 5	Re	esidence 6	01	ther:
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o f	After	Ë	27. Manner of Death 1 ✓ Natural 5	Dan dina		ate of Inju	ear)		,,		Yes 2	_					
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ivis or A	after Dire	≝	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
□ I ^{pj}	neral filler	Certification:	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
e =	within 24 hours after death To the Funeral Director; completely filled in by the	Sa	(Check only 1 Certification Constitution Certification Cer	ying Phys	sician: To the ner:On the ba	best of m	y knowledge mination and	, death oci I/or investi	gation, in m	y opinio	n, death o	occurred	at the time,	date an	d place, and	d due t	o the cause(s)
To P	withi To th	Medical	29b. Signature and title of		and mann	er stated.	1				se numbe						(Month, Day, Year)
		2	29b. Signature and title of	Ceruno	, ,	X			1	O.C	.M.E.				April 22,	2008	•
			all	1		_\		(30)							_		
	5	1	30. Name and address of		ho completed ssistant Me	cause of c	reatn (Item 2 xaminer	:за) 111 Ра	enn Stree	et, Ba	Itimore.	, MD 2	1201				
			Zabiullah Ali, M 31. Date filed (Month, Da				ar's Signature			.,							
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DHMH 1					100	CO VE		ORIGIN	IAL								

08-02970 Jan

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nes Howell		State of Maryland / Department	of Health and Mental H		200	8 1315
	R	For State Certificate of Certificate	of Death	Reg. N 2. Date of Death	lo.	3. Time of Death
Physician	-	. Decedent's Name (First, Middle, Last)		Month Da April 16, 2008	y Year	1140 hrs
al Examin	9,	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	4	Johns Hopkins Hospital	Baltimore	1.00	NA	
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)			IM/DD/YYYY) 9. Birt Foreig	hplace (State or
Director	1		Months Days Hours Mir	Jan: 14.1		untry) N. C.
	12	Isual Residence of Decedent		19001.1.1		10d. Inside City Limits
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nd show	٦	Ma. N/A Bayti	more		Citizen of What Cour	
faryla	Director	IOe. Street and Number	10f. Zip Code	10g.	Citizen of What Cool)
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ms 2.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White, etc.	can indian, black,
or ite	딃	Never Married 2 Name 1 Yes 2 X No	Yes 2 V No specify:		Specify: R	ark
s after		3 Widowed 4 Divorced If Yes, Give Year 11 15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of		b. Kind of Business/	Industry
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21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once	Be	Frank Howell	Ann	10 00	nes	Zin Codo)
D 21215-003 should be filed within and Mental Hygiene. This marked other that event, the Mediatic event, t	P	M. Information Control of the Contro	illing Address (Street and Number of	Rural Route Number	Pr, City or Town, State	1.4.21217
MD of 2 shoulth and on 27 is		MS. Katrina Burroughs 120 Place of Die	sposition (Name of cemetery,	Date 2	20c. Location - City or	Town, State
TOTE, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland ant of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	. 1	1 V Burial 2 Cremation 3 Removal from State crematory of		26/2008	Think	W MI
iment page ment tant:		4 Donation 5 Other Specify:	2 Name and Address of Facility	3.2/0.00	Dunaai	n, 111a.
Baltimore, permit. Pages 1 ar Department of He Important: If ite		2) Signature of Funeral Service Licensee	Toseph L. Russ	uneral,	Home P. H	1216
Physician	-	236 Part I. Eriter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arres	, shock, or heart	Approximate Interval Between Onset and
Mical		failure. List only one cause on each line.				Death
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of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	Completed by		26.Place of Death (Che		VINO I	103 2 10
ision of Vital F Attending Physician: "r deduration After this certific by the funeral director, i	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outp.	Othor		Residence 6 Ott	ner:
of Vij g Physi fter this	<u>P</u>	1 V Yes 2 No 28a, Date of Injury 28b, Tim	ne of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
on C nding th. r: Afi	틸	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division tal or Attendii sa after death.	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be	, street, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Divis Di	er.	determined (Specify)				
E 7 7 9	je	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.	occurred at the time, date and place,	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
To the Hos within 24 h To the Fur completely	edical	and manner stated.	29c. License number		29d. Date signed (I	
	Σ	29b. Signature and title of certifier	O.C.M.E.		April 17, 2008	
		Yamai Buthall, Mt				
4		30. Name and dedress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimor	e, MD 21201		
	tate	32 Pagetrar's Signature	1 4			
Regi		A D D D D D D D D D D D D D D D D D D D	porter			
DHMH 17 Rev 1/	2001	ORIC	SINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** IRIS JONES 11:15PM April 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 SOUTH CAROLINA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/14/1916 **Funeral** Days Months 216-03-0548 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examinant traut by netified at once. 1 ☐ Yes 2 No Director MD BALTIMORE WOODLAWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 SEAMUS COURT 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 □Yes 2 No BLACK Specify ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS TAILOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZACK JONES WILLIE MAE COHEN ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 SEAMUS COURT, BALTIMORE, MD 21207 SHEILA LAWSON / NIECE 20b. Place of Disposition (Name of NACARENE BAPTIST CHURCH CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 4/29/08 PINELAND, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Inter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death di Cause (Final **Physician** TERMINAZ BREAST dise or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transit The law requires that the death certificate be exec Due to (or as a consequence of) attending physician Physician/Medical the ' as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a t be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 12 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

State 31. Date filed (Month, Day, Year)

Registrar APR 2.3 201



ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

April 21, 2008

PHISTIMSTOWN MO

DHMH 17 Rev 1/2001

Maryland 21215-0036

altimore,

Box 68760,

P.0.

Division of Vital Records,

3-03087 onald J. Jordan		ndelible Ink. Ensure All Copies A artment of Health and Mental Hygie	
	- For State Ce	rtificate of Death	Reg. No.
Physician/ "pal Examiner	Decedent's Name (First, Middle,Last) RONALD JOSEPH JORDAN	1 м	ate of Death Ionth Day Year Oril 21, 2008 3. Time of Death 0244 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (In yrs.	Randallstown last birthday) If Under 1 Year If Under 24Hrs. 8.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Directory	215~78~1717 XXTM 2 F 42		Mar. 14,1966 Foreign Country) MD.
	Usual Residence of Decedent		10d. Inside City Limits
T TOW SUN		y, Town or Location altimore County	1 Yes 2 XXNo
he Maryland t or 28a-f sh iffed at once Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	212 Leslie Avenue	21236	USA
er death with or items 23 r must be no Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	
safter de ral", or niner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	specify: White
hours "natur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry State Highway
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar Completed	12th grade N/A	Engineering Associate	Administration
21215-0036 vithin 7 Mental Hygiene. marked other than it event, the Medical Forest other than it event, the Medical Fo Be Comple	17. Father's Name (First, Middle, Last) John Hill Jordan, Sr.		st, Middle, Maiden Surname) atherine Nigrin
2121 ould be fil d Mental Is s marked tic event,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	
MD nd 2 should hand and m 27 is aumati	Margaret L. Jordan (Wife)	212 Leslie Avenue Balti	more, Maryland 21236
Ore, ges l ar t of Her ther tr	1 XX Bunal 2 Cremation 3 Removal from State	crematory or other place)	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	4 Donation 5 Other Specify:	ardens of Faith 4-25-	7401 Poloin Pd
Ba Dep Dep III	23a. Part I. Enter the disease, or complications that caused the dea	Lassahn Funeral Hom	Baltimore. Md. 21236
msit Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)	of):	
execu an and al - tra	d. X UNPENDED X HAVE TO THE T	-070 5 /6 /00 mm	
certificate be anding physici ise as the buri	230. If yes, outdone of pro	egriancy	23d. Date of delivery
that the death certificate be ned by the attending physici detached for use as the buriby Physician/Med	past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal death 3 Ectopic pregnancy death 5 Other (Specify)	Month Day Year **
cords, P.O. Box aw requires that the death has been signed by the attendance of a should be detached for unleted by Physic	Part II. Other significant conditions contributing to death but no	t resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown
- S . 60 2 -			24a. Was an 24b. Were autopsy findings available
Records, The law require frate has been sig			autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
al Re	25. Was case referred to medical	26.Place of Death (Check only	
of Vital Records, ng Physician: The law requir when this certificate has been smeral director, page 2 should no. To Be Completed.	Tes 2 No	ER/Outpatient 3 DOA Other; Nursing H	
_ = ≛ . ` ∉ I ⊼	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work? 28c 1 Yes 2 No	d. Describe how injury occurred
DIVISION O spital or Attending bours after death, neral Director: Aft filled in by the fune Certification:	2 Accident Investigation	t home, farm, street, factory, office building, etc. 281	f. Location (Street and Number or Rural Route Number, Cit
Div Hospital or 24 hours afte Funeral Dii tely filled in	4 Homicide determined (Specify)		or Town, State)
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Corr	one) 2 Medical Examiner: Dn the basis of examination	edge, death occurred at the time, date and place, and due n and/or investigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
To with	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 21, 2008
ø	30. Name and address of person who completed cause of death (It Ling Li, MD Assistant Medical Examiner 1	em 23a) 11 Penn Street, Baltimore, MD 21201	
State			
Registra	APR 2 3 ZUU8	t sperie	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 610 PM ones 2008 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner mw andalistur DUMMOR CUIUNI ITUI 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 8 6. Sex Funeral 7. Age (In yrs. last birthday) ^{Year)} 1941 1 □ M 2 🖫 F 218-38-3221 Director July Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machael Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDBaltimore Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5409 Lewellen Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 □Yes 2√2 No Specify. Specify: black 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nursing/health care LPN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Luther Cook Eugenia Chase ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugena Gunthrop (daughter) 7406 Lesada Dr., #1B, Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-08 Baltimore, MD Woodlawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** encephalo disease or condition resulting in death) anaxic /Medical Due to (or as a consequence of): **Examiner** epiglomi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dianete 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed r this certificate had director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Dea Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hound the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000000000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lainst Keistersbum, MD 21136 MICHELKIN 31. Date filed (Month, Day, Year) APR 23 32 Registrar's Signature State 2008

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Registrar

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			For State Registrar		State	of Ma	ıryland	/ Dep <i>Ce</i>	artment of F rtificate of	lealth and Death	Mental Hy	giene Reg. No		8 (13159
'n			1. Decedent's Name (First, M	liddle, Last)						2. Date of De	eath Day	, v	ear	3. Time of Death
O.	Physici /Medic		FLIZAB	ETH		1<0	ZAR	SKI			04	18		80	8104 m
1	Examin		4a. Facility Name (If not instit Good Samarit				е		4b. City, Town, o Baltin	r Location of Deal	th		County of altim		City
	Funeral Director		5. Social Security Number 215 18 3194	6. Se	х] м 2 ∑ F	7. Age	(In yrs. la	st birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1924'	9 De	Birthpl Count	ace (State or Foreign ry) .a, PA
	ס		Usual Residence of Deceder			·	10.00							140	
	anylar ehow	ž	10a. State 10b. Co	•				Town or L						10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	ecto	Maryland Balt:	more			Baltı	nore C	10f. Zip Code	·		10a Cit	izen of Wha	at Count	
	23a or	Funeral Director		rive					21220			USA			
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hyglene. Is marked other then "natural", or Iteme 23a or 28a-f show reumatic event, its Medical Evaninar must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Divo		12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2 ☑ N live		. 13.	Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2√2 No	tispanic Origin? (s an, Mexican, Puer Specity:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Black, Specify:	America White, e	etc.
8	2 hour	ed t	15. Dec	edent's Edu	cation	-		16a. Dece	edent's Usual Occup	pation		16b. K	ind of Busir		
Maryland 21215-0036	within 72 ine. ihen "nz • Medis	Completed	(Specify only h Elementary/Secondary (0-	ighest grad	College N/A		+)	(Give	e kind of work done DO NOT use retire Employed	during most of wo d)	orking	Jani	torial	Rus	iness
0 0	Hygie ther	ပိ	17. Father's Name (First, Mid	idle, Last)	IV/ A			<u> 2611</u>	пртолеа	18. Mother's Na	me (First, Middle				1 1000
ylan	Mental Mental arked o	To Be	Nicholas Pusl	oski						Julia Br					
Mar	ind 2 sho alth and 27 ie m ar treum	8	Valerie K. McD	ionship (T) DNOUGh	урв, Print) (Daugh	nter)		19b. Mail 120 R	ing Address <i>(Street</i> iverthorn R	and Number or A load Balt	iural Route Numb imore, Mary	er, City o Land	21220	ate, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked ent injury or other treumatic en <u>one.</u>	1	20a. Method of Disposition ↑XX Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			n State	cei	netery, cre	osition (Name of ematory or other pla		Date 2008		imore,M		
3altir	ermit. P epartme nportan ny injur nce.		21. Son ture of Funeral Ser				136.3	2	aus Cemeter 2. Name, and Addre Lassann Fun	era L Home	Inc				ли
	00 = 0		23a Part Enter the disease		SChr.	Calledo	the death		7401 Belair				21230)	Approximate
>	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset a												
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50, k	icate be executed physicien and s the burial-transit	i Exal	that initiated events resulting in death) Last		c. Due to	o (or as a	a conseque	ence of):						T	
387	physi the t	dicai			d									+	
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ŧ		birth gnant at	of pregnan 2 Fetal of time of dea	death 3	□Ectopic pregnanc □ Other (specity) _	у			23d. Date of Month		ry Day Year
Js, P.	ires that signed by	by Ph	Part II. Other significant con	ditions co	ntnbuting to	death bu	ut not resul	ting in the	underlying cause giv	ven in Part I.	1	tobacco		ute to th	e cause of death?
COLC	w requires been si	ojeted				·					24a. Wa	an	24b. We	re autor	osy findings available
al Re	Physician: The lav this certificete has al director, page 2 :	Completed									auto perf 1 🗆 Yes	opsy ormed? 2 No	dea	or to con ath? Yes	npletion of cause of 2 No
Zii	ician: Th certificete rector, pag	Be	25. Was case referred to me examiner?	1	Hospital:				Ott		eath (Check only				
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sion	ending eath. or: After he fune	ation	1 Natural 5 P	restigation	28a. Date (Mo	nth, Day	(Year)	Injury	Wo	rk?]Yes 2□No					
DIX	2 to the state of	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	ould not be termined	289. Plac	e of Inju ding, etc	ury - At hor c. (Specify)	ne, farm, s	treet, factory, office		28f. Location City or To			or Rura	l Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edicai (29a. Certifier 1 Certifier (Check only one)	tifying Phy lical Exem	iner: On the	ne best of basis of nner sta	examination	ledge, dea	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s , date an) and mann d place, and	er as st	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of co	ertifier).				29c. Licens				ite signed (Day, Year)
			Ofper	engl	lus		ooth /li-	22-) (7		8987		41.	21/20	80	
	7		30. Name and address of pe	G, M	D. 5	601	10	CH F	RAVEN BL	UD BA	LTO. M	D &	11239	>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per fb 8878 4-29-08 vt.
State of Marylane? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day April 18,2008 Physician 10:21 P M Nicholas Klembarsky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F 64 Yrs. 161-34-8787 May 10, 1943 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 No Maryland Prince Georges Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 8102 Chapel Cove Drive 20707 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tayes 2 No 61-65 If Yes, Give Year or Dates: 1 ☐ Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical College (1-4or 5+) Elementary/Secondary (0-12) Communications item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Klembarsky Margaret Cyrnak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy M. Klembarsky- wife 8102 Chapel Cove Drive, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metroploitan Crematory 4/23/2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. 161234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Disease Years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE: ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1□Live birth 2□Fetal death 4□Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 No 1☐ Yes 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) MABYLAND 20707 AME W 31. Date filed (Month, Day, Year) State APR 23 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month. Day Year Physician /Medical 3:34 A M . arry 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (It not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/20/1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 65 469-50-3797 MINNESOTA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a State 10b. County 1 X Yes 2 □ No Director HOWARD COLUMBIA MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ Pages 1 and 2 should be filed within 72 hours after death with must be 23a 10921 SHADOW LANE 21044 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. th and Mental Hygiene. 7 is marked other than "natural", or ite traumatic event, the Medical Examiner 1 Yes 2.5
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No þ 3 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) JOHNS HOPKINS APPLIED Elementary/Secondary (0-12) College (1-4 or 5+) PHYSICS LABORATORY ELECTRICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ LIBBIE VOTAVA JIMMIE LEVY ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health au Important: If item 27 Is any Injury or other trauonce. MERIDEE LEVY / WIFE 10921 SHADOW LANE, COLUMBIA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEM. PARK 4/26/08 ELKRIDGE, MD meral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 10220 GUILFORD ROAD, JESSUP, MD 20794 complications that caused the death Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1.45 shock or the disease, or complications that caused to the failure. List only one cause on each line Onset and Death Immediate se (Final Stroke **Physician** week ondition resulting in death) /Medical Due to (or as a consequence of): Examiner to (or s) consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? ate has been signed by the atter page 2 should be detached for Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examine? 1 🗌 Yes 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? Hospital: 1 npatient Other: 4 \sum Nursing Home 1 ☐ Yes 200 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 Nes 2 No after death. 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

Division of Vital Records, P.O. Box 68760, 24 hours a Hospital

State Registrar

within 2

harles 31. Date filed (Month, Day, Year) APR 23 2008

(check only one)

29b. Signature and title

rown IV Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

KES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

21,2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03041 State of Maryland / Department of Health and Mental Hygiene 2008 13162 Amanda Marie Lorenzo Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 19, 2008 0054 hrs Marie Medical Examiner Amanda Lorenzo 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Rousby Hall Road and Chestnut Drive Lusby 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Linder 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Hours 03/07/1980 373-02-4881 Davs MI 28 Director 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No VA Loudon Ashburn 28a-f show hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20147 45136 Waterpointe Terrace, Apt. 201 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 Yes specify: White 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ≥ r Date 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) mit. Pages 1 and 2 should be filed within 72 liparment of Health and Mental Hygiene.
portant: If item 27 is marked other than "n ury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Education Teacher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julie Charbeneau Mickey Baron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47839 Jefferson Avenue, Chesterfield Twp, MI 4804 Mickey Baron, Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Invin Cremation Service Furial 2 X Cremation 3 X Removal from State 04/22/2008 Clinton Twp., Michigan Donation 5 Other Specify: 22. Name and Address of Facility Will & Schwarzkoff FH, Inc. 21. Signature of Juneral Service Licenses M01113 233 Northbound Gratiot Ave. Mt. Clemens, MI 1 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line 'Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit * AMENDED 20a-c per fh g879 5-16-08 vt Physician/Medical UNPENDED signed by the attending physician be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 V Yes Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other4 examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day Year) Apr 19, 2008 28h Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Passenger in motorcycle fixed object 1 Natural 0049 hrs 1 Yes 2 V No Pending collision 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Rousby Hall Road and Chestnut Drive, Lusby, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier

a

State

Registrar

ogistrar's Signatur

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2008

Margarita Korell MD.

31. Date filed (Month)

O.C.M.E.

April 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** April 16 2008 11:25A^M Rose H. Landsman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Morningside House Ellicott City If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
Aug. 11,1917 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛭 F Mary land 90 Aug. Director <u>216-07-2861</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐Yes 2 XNo Funeral Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 U.S.A. 5330 Dorsey Hall Drive #225 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

National Inst. of Mental Health than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other the apprehence of the property or other traumatic event, the long. Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Hartman Anna (Unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan L. Garner (Daughter) 5669 Harpers Farm Road Unit B Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2008 4 □ Donation 5 □ Other (Specify) Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licensee ^{22.Name and Address of Facility} Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Col K. Hademo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Columbia, MD 21045 Immediate Cause (Final disease or condition resulting in death) DISCUSC A / Kero sclewic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Tes 25 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assured Wil Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimor RIVER NECK KOUD 201-109 Sahapalhi

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 21, 2008 **Physician** 1:00P Mary Louise Levy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Blakehurst Care Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 8, 1915 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 3√F Months Days Hours Delaware 217-07-6595 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes XX No Directo Baltimore Towson Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 USA 1055 West Joppa Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify. þ White XX Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Rice Smith Martha Layfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Joan Cromwell Hammond DTR 232 Brandon Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition

WX Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State April 26,2008 | Pikesville Maryland Druid Ridge Cemetery Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Se 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Physician Aspiration /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2PT No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No nours after death. neral Director: A filled in by the fo 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

10

William 32. Segistrar's Signature 31. Date filed (Month, Day, Year) **APR 23**

who completed cause of death (Item 23a) (Type, Print)

D. McConsell M. Charles

Baltimore 1

		Please Type	or Print in B	ack I	ndelible Ink.	Ensur	e All Copi	es Are	Legible		
			te of Maryland				nd Mental I	Hygien	е		
		1 - State Registrar		C	ertificate of	Death	0.04	Reg. N	0. 200	18.	1316
Physic	ian	1. Decedent's Name (First, Middle, Last)	D 0 15				2. Date of Month	D	ay Yea		12: 20 PM
/Med		HIKMAT MAK 4a. Facility Name (If not institution, give street a	KAWI nd number)		4b. City, Town, o	r Location of	A PR		c. County of D	3	12.200
Exami	iner	HARROR HOSPI	_		BALT				o. Godiny of B	oun	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthda			4 Hrs. 8. Date o	f Birth	9.1	Birthpla Countr	ce (State or Foreign
Director		593-48-3730 1□ M 21	₫F 80	Yrs.	Months Days	ricuis	8-05	-192	7		banon
and		Usual Residence of Decedent 10a. State 10b. County	10c. City,							100	I. Inside City Limits
Maryl-f sho	ţō	MA NA	Wes	t Sp	ringfiel	.d					1 □Yes 2 No
h the r 28a r notif	Director	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What	Countr	y?
th wit 23a o 1st be	aD	49 Timber Ridge Ro	ad		0108	39		L	ebanon	l	
r dea	Funeral	Arm	s Decedent Ever in U.S led Forces?	. 1:	3. Was Decedent of H	lispanic Origi an, Mexican,	n? (Specify Yes o Puerto Rican, etc	r No- .)	14. Race - A Black, W		
s afte	by Fi	li Y	Yes 2 v No es, Give r or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify:	Whi	lte
filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	ed	15. Decedent's Education	of Dates.	16a. De	cedent's Usual Occup	ation		16b.	Kind of Busine	ss/Indu	strv
in "na Medic	plet	(Specify only highest grade comp	leted) ege (1-4or 5+)	(Gi	ve kind of work done b. DO NOT use retired	during most o d)	of working				
d with	Completed	12th	NA	Ноц	sewife		- N	A 1	t Home	!	
oe file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					s Name (First, Mi				
y could loud larke	은	Muheedin Makkawi					ouent				
d 2 sh th and 7 Is m		19a. Informant's Name/Relationship (Type. Print Bilal Makkawi - So	·		illing Address (Street			-			
Healt Healt	ļ.,	20a. Method of Disposition			O Stourh position (Name of rematory or other place		Date		Location - City		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		ty Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	nom State		rematory or other plac orial Park		-20-08		dallst		
mit. F partme ortan Injur		21. Signature of Funeral Service Lioposee	پسر		22. Name and Addre					- O W	117 112
any men		Elerane H.	Thompso		arch Fun Baltimore		ноme W	est,	inc.		
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the eath.					ory arrest,			Approximate nterval Between
Physician		Immediate Cause (Final	CINETOI	BAC	TER PI	VEUN	PINOL			8	DAYS
/Medical Examiner			ue to (or as a conseque								- , -
LXammer		Sequentially list conditions, b.	ue to (or as a conseque	ance of):						-	
ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	ue to (or as a conseque	silce oi).							
be executed cian and ourial-transit	Examiner	triat irritated events	ue to (or as a conseque	ence of):						+	
ysicia e bur	-	d									
rtifica ng ph as th	Medi	IE EENALE.									
death certificate be attending physicial for use as the bu	Physician/Medica		es, outcome pf pregnan Live birth 2 🗆 Fetal		3 □Ectopic pregnancy	,			23d. Date of		
ie dea the at	sici	1 Vas 2 No 4L	Pregnant at time of de Unknown	ath :	5 ☐ Other (specify) _			-	Month	L	ay Year
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur		Part II. Other significant conditions contributing	a to death but not resul	tina in the	underlying cause giv	en in Part I.	23e.	Did tobacco	use contribute	e to the	cause of death?
uires signe	d by	MITRAL STENOSI			TIC HE		SEASE	1 □ Yes	2 □ No 3 🔀	Probal	oly 4 □Unknown
w require been signature	Completed	END-STAGE REN	,					Was an	24h Were	autons	sy findings available
The lav	m C	END STITLE REIV	IL PISE	30			— i	autopsy performed?	prior death	to comp	oletion of cause of
i cl an: Th certificate ector, pag	O)	25. Was case referred to medical				26. Place o	of Death (Check o	res 2 🔼 N	\o 1 □ \	es 2	□No
Attending Physician: r death. ector: After this certifice by the funeral director.	To B	examiner? 1 ☐ Yes 2 No Hospital	1 ⊠ Inpatient 2□8	R/Outpat	ient 3 DOA Oth	er: 4□ Nurs	sing Home 5	Residence	6 □Other (S	pecify)	
ding Pr		27. Manner of Death 28a. 1 ☑ Natural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time Injun		y at k?	28d. Desc	ribe how inj	jury occurred		
tendl eath. tor: A	Certification	2 Accident investigation				Yes 2 □ Ne	-				
or At fter d Direct in by	T.	4 Homicide determined 28e.	Place of injury - At hon building, etc. (Specify)	ne, farm,	street, factory, office			on (Street a r Town, Sta	and Number oi ite)	Rurali	Route Number,
spltal ours a leral I		29a. Certifier 1 ☑ Certifying Physician:	To the best of my know	ledge, de	eath occurred at the til	me. date and	place, and due to	the cause	(s) and manne	r as sta	led.
e Hos 24 h e Fur letely	edical	(Check only 2 Medical Examiner: Or	the basis of examination manner stated.	on and/or	investigation, in my	pinion, death	occurred at the t	ime, date a	ind place, and	due to t	he cause(s)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. D	ate signed (M	onth, D	ay, Year)
		> phydriston.				000		AP	RIL, 1	9,	2008
Ì		30. Name and address of person who complete	d cause of death (Item :	23a) (Typ	e, Print) RACH	ANA	PALNIT	FRAR.	HARBO	RH	IOSPITAL,
		3001 SOUTH HAI 31. Date filed (Month, Day, Year) APR 23 2008	VOVER ST	2 66	, BALT	IMOR	E, MD	2127	25		
St Regis	trar	31. Date filed (Month, Day, Year) APR 2 3 2008	A. Hegistrar's Signat	ILE NO.	BALL						

			Please	Type or Prin								
		-	For State Registrar	State of Ma	ryland	/ Departm			vientai Hy		0000	10166
			Registrar 1. Degedent's Name (First, Middle, Las	t)		Certino	ale oi	Dealii	2. Date of D	Reg. No.	2006	3. Time of Death
Phys			Randolds	MCCOU					Month	1 S Day	2008	6:55PM
/Me Exa	edica mine		4a. Facility Name (If not institution, give	000		-01		r Location of Death		4c.	County of Deat	
Fune	ral		5. Social Security Number 6. Se	7. Age	(In yrs. las	t birthday) If U	nder 1 Year	If Under 24 Hrs.	8 Date of B	irth	9. Birt	hplace (State or Foreign
Direct			216-36-1738	X M 2□ F	68	Yrs. Mon	iths Days	Hours Min.		eg, Year) 18	39	MD
pu	20		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Location						10d. Inside City Limits
Aaryla f sho		ō	MD NA			altimo						1 X Yes 2 □ No
r 28a-		rec	10e. Street and Number			101	f. Zip Code			10g. Citi	zen of What Co	
th with		Funeral Director	727 Druid Park	Lake Dr	ive	#13F	2	1217	_		U.S.	A •
er dea		nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was D If Yes,	ecedent of I specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	lo-	 Race - Ame Black, White 	
illed within 72 hours after death with the Maryland Hygiene. Hygiene. Suber than "natural", or items 23a or 28a-f show ant the Maryland Frammer must be collined at		2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 N If Yes, Give Year or Dates:	0	1 □ Y€	es 2/1 No	Specify:			Specify: B	lack
72 hou		Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Decedent's	Usual Occup	pation during most of wor	kina	16b. Ki	nd of Business	Industry
ithin 7		du l	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO	OT use retire	d)		Ron	Secon	rs Hospita
C C L C IIII IIII IIII IIII IIII IIII I			12th grade 17. Father's Name (First, Middle, Last)	4yrs		Mental	пеал	18. Mother's Nan				es mospess
Viarro Vuld be file Mental H arked oth		m	Fredrick McCoy					Nellie	Atkir	ıs		
and and Is m			19a, Informant's Name/Relationship (7	Type. Print) Wif	е	19b. Mailing Add	dress (Street	and Number or Ru	ıral Route Num	ber, City o	r Town, State,	Zip Code) 21218
1 and 2 1 and 2 Health Sem 27			Marvanuel Russe	ell McCoy					Date Date		ocation - City or	
Pages 1 nent of h			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		ce of Disposition netery, crematory		1				
Dallillor permit. Pages Department of Important: If it	aj l		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	A : /	Met	22. Nan	ne and Addr	y Inc 4	/23/08	Ba Ba	altimo	re, Ma
permit. Departr	once		Mumio	DIL	2 6	Mar 430	ch F/	H West ash Ave	. Balt	imo	ce, Md	21215
			23a. Part 1. Enter the disease, or compand shock, or heart failure. List only	olications that caused	the death.	Do not enter the	mode of dy	ing, such as cardiad	or respiratory	arrest,		Approximate Interval Between
Physici	an		Immediate Cause (Final disease or condition	· Motz	520	tre h	no c	ance/				Onset and Death
/Medic			resulting in death)	Due to (or as a	conseque	nce of):	0					
LXamm		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	a conseque	nce of):						
outed d		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
C, A e exec ian an urial-tr		Exa	resulting in death) Last	Due to (or as a	conseque	ence of):						
OO/O		dical	•	d		-						
X O Sertific Sertific Se as		Mec	IF FEMALE:	23c. If yes, outcome	of pregnan	CV					23d. Date of de	divory
DOX death ce attendii		Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant at	2 🗌 Fetal o	death 3 🗆 Ecto	pic pregnan er (specify) _	су			Month Month	Day Year
t the d by the		hysi	9 Unknown	9 Unknown								
ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director name 2 should be detached for use as the burial-transit		by P	Part II. Other significant conditions of	ontributing to death bu	it not result	ting in the underly	ring cause gi	ven in Part I.				o the cause of death?
cords, w requires to been signed should be a	5								11	JYes 2	□ No 3□ F	
he law e has b		Completed								as an topsy rformęd?	24b. Were a prior to death?	utopsy findings available completion of cause of
alr n: Th ficate	-		oc We						1 □ Yes	2 X No	1 ☐ Ye	s 2 🗆 No
VICAL /Sician: 7 /Sician: 7 /Sician: 7		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Inpatie	nt 2 DE	R/Outpatient 3	DOA Ot	26. Place of Dea			6 ☐ Other (Spe	ecify)
g Phy gerthis		i.T	27. Manner of Death	28a. Date of Injui	ry 2	28b. Time of Injury	28c. Inju		28d. Describ			
SIOF endin eath. or: Af		atio	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1			1 1]Yes 2□No				
INISION or Attending after death. Director: After		Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	iry - At hom c. <i>(Specify)</i>	ne, farm, street, fa	actory, office			Street ar own, State		iural Route Number,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the				nysician: To the best on the basis of the ba								
the Harin 24 the Fu		Medical	one)	and manner sta		on and or investig						
P # P 6	3	2	29b. Signature and title of certifier		50 0	11	29C. Licer	se number		290. Da	ite signed (Mon	17 ETD D
,			30. Name and address of persop who	completed of the of the	R. Be	TYWEND PRINT	1116	7201			7/13	12000
1			HIW. 4015	St. Su	170 -	212 A	Ba	Ohmor	e, N	10:	2121	
*	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	sparte !	9		- (
Reg	jistra	if	HATIN IL O LUIC	The state of the s		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N artificate of Death		0000
			Registrar 1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Death	3. Time of Death
	Physicia		Delia Damico McBride		Month 4/18/	Day Year
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4/10/	4c. County of Death
	Examin	ei	20960 Colton Point Rd.	Colton Point		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	
	Director		578-18-7083 1 □ M 2 🖾 F 88 Yrs.	Months Days Hours Min.	7/29/19	Washington, D.C.
	pu ,		Usual Residence of Decedent			10d. Inside City Limits
	aryla shov	5	10a. State 10b. County 10c. City, Town or L			1⊠Yes 2 □ No
	he M	ecto	MD Prince George's	Greenbelt	140	g. Citizen of What Country?
	a or s	ä	10e. Street and Number		10	
	is 23	eral	13 N. Hillside Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	20770 Was Decedent of Hispanic Origin? (Sp	ecify Ves or No-	U.S.A. 14. Race - American Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Predical Experiment out the motified.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
Ö	2 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	ina 10	6b. Kind of Business/Industry
21	within 7 iene. • than "r	nple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	my (Goddard Space
21	filed wi Hygien other th ent, the	Con		a Analyst		Flight Center
Maryland	be filed valued Hygined other ed other	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Surname)
<u>Y</u>	should be and Menta marked umatic ev	2	Alphonso Damico		Spinozzi	
Mai	nd 2 sh alth and 27 Is n r traun			ing Address (Street and Number or Rui		
.	1 and Health em 27			Freeport St., Hya osition (Name of ematory or other place)		Oc. Location - City or Town, State
Baltimore,	ages ent of t: If it		1 M Buriai 2 Li Cremation 3 Li Removal from State		1/2000 1	Sandana tanan D. C.
₽	artme artme ortan injur			ret Cemetery 4/23 22. Name and Address of Facility	3/2008 W	ashington, D.C. 4739 Baltimore Ave.
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.			·	me. P.A.	Hyattsville, MD 20781
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en			st. Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Failure to Thrive Due to (or as a consequence of):			
1	Examiner		Sequentially list conditions b. Advance Dementia			
	₽ 1./=	iner	if any leading to immediate Due to (or as a consequence of):			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. Colon Cancer			
60,	icate be executed physician and the burial-transit	E	resulting in death) Last Due to (or as a consequence of):			
68760,	ficate be executed physician and s the burial-transit	dical	d			
×	death certific e attending p d for use as	//Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death e attel	Physician/M	in the past 12 months? 1 Live birth 2 Live birth 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
0	the oy the acher	hysi	9 Unknown			
٠, ص	requires that the de een signed by the a nould be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ğ	v require been sig should b	ed t			1 ☐ Yes	3 □ No 3 □ Probably 4 🖾 Unknown
Records,		Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	<u>ө</u> <u> </u>	mo			perform	ed? death?
Vital	nysician: Th nis certificate I director, pag	Be (25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one	
of V	S S =		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		ome 5 🗆 Resider	nce 6 Nother (Specify) Friends Home
		on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe hov	v injury occurred
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place of Injury. At home form of	M 1 □Yes 2 □No	004 1	
	or A	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town,	eet and Number or Rural Route Number, State)
_	pltal ours eral filled		29a. Certifler 12 CertifyIng Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the ca	use(s) and manner as stated
	To the Hospital or Attene within 24 hours after deatt To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	te and place, and due to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	/) Ashan	D47066		April 21, 2008
	h		30. Name and address of person who completed cause of death (Item 23a) (Type			
	J		Avani Shah 22650 Cedar Lane Court,		650	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 2008 Registrar's Signature	ule		

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Maryl	,	artment of H		_	giene Reg. No.	08	13168	
			Decedent's Name (First, Middle, Last)					2. Date of De.		Year	3. Time of Death	
	Physici /Medic		Paul Douglas McPhe	rson, Sr.				April	19, Day 20	08	10:30 A M	
	Examin	-	4a. Facility Name (If not institution, give s			4b. City, Town, o	Location of De	eath		nty of Death		
			Holy Cross Rehab.	& Nursing C	enter	Burtonsv			Mont	gomery	7	
	Funeral Director		220-30-2330	7. Age (In)	rs. last birthday)	Months Days	If Under 24 H	lin. 8. Date of Bird (Month, Da Mar 29	y, Year) 1939	Cou	place (State or Foreign ntry) Yland	
•	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits	
	f eho	ō	MD					1. Yes 2 □ No				
-	28.	reci	10e. Street and Number	ра	1timore	10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
3	30 OF		4514 Wakefield Roa	.d		21216			USA			
1	me 2	Funeral Director	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No		lace - Amen		
9	within 72 nouts affer death with the Maryland ene. Then "naturel", or lleme 23e or 28e-f ehow ne Michel Exanirer must be incliffed at		1 Never Married 2 Married	1 ☐ Yes 2 🐼 No If Yes, Give	ì	1 ☐ Yes 2X No	Specify:	iento moan, etc.)				
900	ure!;	d by	3 ☐ Widowed 4 🏠 Divorced	Year or Dates:						cify: B1ac		
2	nat	lete	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of a	working	16b. Kind of	Business/Ir	ndustry	
-61717	with ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		al Mixer	•/				(unk)	
0	Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle,	Maiden Sum	ame)		
land	fenta fenta rked ilc ev	To B	Benny Parker				Blanch	e McPhers	on			
Mary	and h	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Number	er, City or Tox	vn, State, Zij	p Code)	
Σ :	eaith n 27 ner tr		Cecelia McPherson/				d Rd. B	altimore,				
	i of H if iter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	amount from Ctata		matory or other place		Date	20c. Locatio			
	tment tent:		4 □ Donation 5 □ Other (Specify)	C		ke Cremat			Beltsv			
Dai	permit. Pages 1 and 2 should be lided within 72 hours after death with the Marylan Dependent of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e or 28e-1 ehow eny injury or other traumatic event, the Michical Examinar most the inclining at one.		21. Signature of Funeral Service License	MO1	251 G	Name and Addre Sing Home Everly L.	ss of Facility Cremat Heckro	ion Servi tte, P.A.	ce P. Clark	0. Boz sville	x 784 e, MD 21029	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	e cause on each line.			-		rrest,		Approximate Interval Between	
	hysician		Immediate Cause (Final disease or condition	Due to (or as a con	ostive	10000	t Sa	ileva.			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	1600						
ı		_	Sequentially list conditions, if any, leading to immediate	 Due to (or as a con	sequence of):							
	B W #	nlne	cause. Enter Underlying Cause (Disease or injury	5 do 10 (01 d3 d 601)	sequence on.							
	n and	Examiner	that initiated events cresulting in death) Last	Due to (or as a con	sequence of):							
0/0	physician and sthe burial-transit	dical										
0	ng ph	Med	IF FEMALE:		-							
Š	tin ce tendii	an/h	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,			Date of deliv Month	ery Day Year	
5	the all	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)				WOLL	Day 16a1	
Ĺ	ad by detac		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause gry	en in Part I	23e. Did to	obacco use co	ontribute to I	the cause of death?	
as,	rine raw requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d b	•	• • • • • • • • • • • • • • • • • • •			or are area.		Yes 2□No			
cords	peer	Completed	24a. Was an							24h Wara autopey findings available		
ב ב	e has	guc						autopperfo	rmed?	death?	opsy findings available ompletion of cause of	
VIII	tificat tor, p	0	25. Was case referred to medical				26. Place of [1 ☐ Yes Death (Check only o	2 000	1 🗆 Yes	2DN0	
> 3	is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ☐ ER/Outpatier	nt 3 DOA Oth		sing Home 5 Residence 6 Other (Specify)				
5 8	ter th		27. Manner of Death t ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injur Wor			ibe how injury occurred			
SIOIS	eath. or: A the fu	catle	2 Accident investigation			M 1 🗆	Yes 2 □ No					
SIVIS	in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tox		mber or Rur	al Route Number,	
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3	in 24 the Fu	edical	(Check only 2 Madical Examination)	nar: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death o	ccurred at the time,	date and plac	e, and due t	o the cause(s)	
F	T with	Σ	29b. Signature and title of certifier	94		29c. Licens			29d. Date sign	1	•	
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	Registr		ADD 9 3 20		Le v	1						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 20 a ULINE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner an ton Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months 1 □ M 2 🖫 F Director Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It item 27s a marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ₽Yes 2 No Director 1timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S 21222 Funeral a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home maker OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OSEDRINE Pages 1 and 2 should ၉ aria UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tratonce. 91042 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CENS 0 Roseda/e nature of Funeral Service Licensee rad/ey - Ashton Funeral Home, · 110W Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Maa /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy Month Dav Year in the past 12 mon 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy death? 1 ☐ Yes 1 □ Yes 2 2 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manne Death 28b. Time of 28d. Describe how injury occurred 1 atural 5 ☐ Pending 1 ☐ Yes 2 ∏No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

APR 23 2008 Registrar

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** eama ZO 2008 TOYI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Social Security Number () 6. Set Examiner MCVE dical Chi 9. Birthplace (State or Foreign Country) Mary Jand **Funeral** Months Days Hours 1 ☐ M 2 💆 F NOV.2' Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural" any filury or other fraumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) na 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type/Print) (Fignce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility Jose ttome unes 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2**√** No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 28b. Time of 27. Manner of Death Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 No I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tide of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street. Weeke

Registrar

State

Elizabet

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South

22

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year **Physician** Marian April 12, S. McCall 12:28 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Brooke Grove Rehab & Nursing Sandy Spring
If Under 1 Year | If Under 24 Hrs. Center Montgomery 8. Date of Birth (Month, Day, Feb. 18, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2/□ F 89 410-12-5824 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fem 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√☐ No Director Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18131 Slade School Rd. 20860 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist Multimedia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Shippy Maude E. Loucks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Umberger- daughter 17620 Buehler Rd., Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Memorial Park 4/26/2008 Gotha, Florida 22. Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Funeral Service Licensee 7250 Sandy Spring Rd., Laurel, MD 20707 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) merastaric cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for as a consequence of if any loading to immodile cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □ Yes 1∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🖾 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) Da63999 Motames.

State

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31. Date filed (Month, Day, Year) APR 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Ata Motamedi, M.D., 18111 Prince Philip Dr., Ste 101, Olney, MD 20832 32 Registrar's Signature

			1 - For State Registrar	State of Mar		Depar	tment ificate	of He	ealth a		lental Hy			8 1	31	72
			Registrar 1. Decedent's Name (First, Middle, Last)		Oerti	incate	OI L	Cairi		2. Date of Dea	Reg. No. ath		3.	. Time of I	Death
	Physici	an	Month								Day 20	Y 21	ear			
	/Medic Examin		4a. Facility Name (If not institution, give		70,0		4b. City, To	own, or	Location of	of Death			County of	,		
	LXuiiiii		FREDERICK VIL	LA N.H.			Cat	tons	ville	9			Balt	imore	<u>,</u>	
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. last bi		If Under 1		If Under 2		8. Date of Birt (Month, Day	th v. Year)		Birthplace Country)		Foreign
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	bug *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Tow	vn or Loca	ution							10d. I	Inside Cit	y Limits
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	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or Itama 23a or 28a-f ehow event, the Medical Exatt the final te maillied at		6264 Old Washingt	on Road				21	075			US	A			
	after death w or Itama 23a Intiper tours	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Wa	as Deceder	nt of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race -	American In White, etc.	ndian,	
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<u>9</u>											20c. Lo	20c. Location - City or Town, State				
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			23a. Part1. Inter the disease, or comp shock, I heart failure. List only of											Inte	proximate erval Betw iset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	altrieri	o Sch	roti	c 6	10	Leo V	2864	day Di	res	rse			
	/Medical Examiner		1	Due to (or as a	consequence	of):	.00	4	00							
3		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	cue	116	3 r)	5	^			-		
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	e dea the at red fo	Sich	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	12 months? 4 □ Pregnant at time of death 5 □ Other (specify)								Month Day Ye			Odi	
7	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	۵.	Part II, Other significant conditions co	ntributing to death but	not resulting	in the und	lartying car	IEO GIVO	n in Part I		23e Did to	obacco u	se contribi	ute to the ca	ause of de	eath?
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5	Physical distribution	E	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient	28b.	Time of		c. Injury	at		28d. Describe t					
0	nding Phy th. : After thi s funeral	tlor	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 Accident investigation 28d. Descri													
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5	s afte	Certification;	4 E Homede	Building, etc.	(Зреспу)						City of 100	wii. State,	,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical ((Check only 2 Medical Exam	sician: To the best of iner: On the basis of e	xamination as	e, death o	occurred at	the time	e, date an inion, dea	d place, th occurr	and due to the	cause(s) date and	and mann place, and	er as stated	d. cause(s))
	the I		29b. Signature and title of certifier	and manner state			290	t icense	number			29d Date	e signed ()	Month, Day,	(Vear)	
	To To COI		250. Signature and title of certifier	enkara			7	211	644	-		Ann	الم ال	1 11	808	
			20 November 1		ab (lane 00)	(T) = C					/	טייןני		, , , ,	0	
	12		30. Name and address of person who can be said address.	SKALAV	34-55°	Wi	lke	ns	AVI	18	ALTIM	ORE	· M	021	229	7
	Sta	ite	31. Date filed (Month, Day, Year) APR 2 3 200		s Signature	An	E)	-							/	
	Registr	ar	I APR Z 3 ZUL	IU KEEKS	Walley .	The same										

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			1 - For State Registrar	State of Marylan	d / Depa		lealth and M	lental Hyg	_	13173		
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death		
	Physic /Medi		James	Ow	ens			Month	7 200 8			
	Exami		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	1100	4c. County of Dea			
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	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year)							rthplace (State or Foreign ountry) Maryland			
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
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	72 hours after death with the Maryland 'natural', or Items 23e or 28a-f show dical Examinar must be published at	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?		
	h with	aiD	6225 York Road	Apt. E211		21212	2		USA	,		
	deat	ner	11. Marital Status	2. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Am			
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12		를	Elementary/Secondary (0-12)	College (1-4or 5+)	me. L	OO NOT use retired COOM)		Race Tra	ck		
2	be filed within ital Hygiene. id other than event, the Me		4th grade 17. Father's Name (First, Middle, Last)		- G.	LOOM	10 Mathada Nama					
an	be do be	Be C	James E. Owens				18. Mother's Name Mabel	Johns	on			
7	2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship (Typ	e Print) Danah ta	10h Mailio	a Address (Street				7.0.11.04.007		
Ma	od 2 s lith ar 27 is 'treu		Carolyn Owens-C	enkins	2106	Lawnwoo	od Circl	e Woo	dlawn, M	aryland		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marks any injury or other treumatic ance.		20a. Method of Disposition	20b. PI								
JUO			1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State Gre	metery, crem eenmo	atory or other place ant Ceme	etery4/2	1/08 B	altimore	Town, State , Maryland		
Ħ			21. Signature of Funeral Service Liverage									
ä	Depa Impo any li		Nerow /	Villia	5	240 Reis	sterstow	acman _B	altimore	uneral ₂ Hgm		
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest									
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	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
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Ö,	e exe ien al ırial-t	EX	resulting in death) Last	Due to (or as a consequent	ence of):							
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39	eath certific ettending pl	Physician/Med	IF FEMALE:						75.	a alexandre o		
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 			23d. Date of de	1				
0	e des the ett	sici	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Month	Day Year		
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ec €	e law has t e 2 s	Completed	(vi)	24a. Was an autopsy	prior to	utopsy findings available completion of cause of						
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Division of Vital	icien certifi ector	Be	25. Was case referred to medical examiner?	anital:			26. Place of Death	(Check only one)			
0	Physicien: r this certifica ral director, p	.T	1 Yes 2 No		R/Outpatient		4 Horring Horr		nce 6 Other (Spe	cify)		
5	Jing After fune	Certification;	1 Aatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	?	8d. Describe how	w injury occurred			
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<u>></u>	in Elife	ertii	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, rarm, stre	et, factory, office	2	City or Town,	eet and Number or Ri State)	ural Houte Number,		
	To the Hospitei within 24 hours a To the Funerai I completely filled		29a. Certifier 1 Certifying Physic	ian: To the best of my know	ledge doost	Occurred at the ti	data and since	ad due to the	/->			
	e Ho 24 h e Fur etely	edical	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	on and/or inve	estigation, in my opi	nion, death occurre	d at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mont	h, Day, Year)		
			144 1 1/4	MO		D 31	295					
	1		30. Name and address of person who com	pleted cause of death (Item 3	23a) (Type P				7/18/00			
	8		wendy Morrz	6701 N Cha	1.45 S	L Sute	4202 7	owsm	4/18/08	2/204		
	Sta	e	31. Date filed (Month, Day, Year) APR 23 200	8 32. Segistrar's Signatu	T2 /				1.2			
	Registra	ar	APK 23 200	O Regue L	1. 60	and a						

08-03108 Cecilia Parker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 13174

		1- For State Registrar		to or maryiaria		ficate of					j. No.			
Physicia ור Exami		1. Decedent's Nam Cecilia		_{Last)} Parker						2. Date of Death Month April 21, 20	Day Year	3. Time of Death 1215 hrs		
			(if not institution, hannel Drive	give street and number	r)	4	b. City, Tov Berlin	vn, or Loca	tion of Death		4c. County of D Worcester			
Funeral Director		5. Social Security I 213–52–2	2526	. Sex 7. A	ge (In yrs. Ias 56	t birthday) Yrs.	If Under	\rightarrow	Under 24Hrs. Hours Min.	8. Date of Birth 07/09/	1951 F	e. Birthplace (State or oreign Country)		
any		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, T	own or Location	on					10d. Inside City Limits		
rland -f show once,	tor	MD	Worce	ster		Berli					1 Z Yes 2 No			
the Mary a or 28a	Director	10e. Street and Nu 30 De		nel Drive			10f. Zip C	ode 1811		10	g. Citizen of What US			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any matic event, the Medical Examiner must be notified at once.	Funeral		ied 2 Marr	ried 12. Was Deceder Armed Forces 1 Yes ced If Yes, Giva Year		If Ye	es, specify (Cuban, Me	xican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - A White, e	omerican Indian, Black, tc. White		
iours afte natural" xamine	d by	3 X Widowed 15. Decedent's E		or Dates: fy only highest grade co	ompleted)	16a. Decedent		ccupation (16b. Kind of Busin	ess/Industry		
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Cor									The second secon				
MD 21; d 2 should b Ith and Men n 27 is mar!	ToE	19a. Informant's N Stephen	ame/Relationship	p (Type, Print) ski / Broth	er	19b. Mailing 8906	Address Chape	(Street and	Number or Renue, E	ural Route Numi 111icott	city or Town,	State, Zip Code) D 21043		
- E ea a 2		4 Donation 5	X Cremation	3 Removal from S	Bay	ace of Disposi ematory or oth VIEW C	ner place)			Date 23/2008	20c. Location - Ci			
Baltimore permit. Pages 1 Department of I Important: If I Injury or other		21. Signature of E	uneral Service Li	Victor	P. Dod	la 22. N	lame and Ad	les I	. Stev	ens Fun	eral Home	e Inc.		
Physician Wedical		23a. Part I. Enter t failure. List or	the disease, or co	omplications that cause n each line.	ed the death. I	Do not enter th	ne mode of	East dying, such	fort as cardiac or	respiratory arre	Baltimo: st, shock, or heart	Approximate Interval Between Onset and Death		
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8760, ifficate be on physicials the buria		IF FEMALE: 23b. Was deceden	t pregnant in the	23c. If yes, outc	ome of pregn		tal death	3 TE	ctopic pregna	ncy	23d. Date of de Month	elivery Day Year		
that the death certificate by the attending detached for use as	Physician	past 12 month		-1	at time of dea	46	her (Specif	ý)						
S 50 9	ğ	Part II. Other sign	nificant conditio	ons contributing to de	ath but not res	sulting in the u	ınderlying c	ause giver	in Part I.			te to the cause of death? Probably 4 Unknown		
of Vital Records, P.O. og Physician: The law requires that nfer this certificate has been signed the neral director, page 2 should be detail	Completed									24a. Was a autop: perfor	topsy prior to completion of cause of			
	е Соп	25. Was case refe	erred to medical				26	S.Place of D	Death (Check	1 ✔ Yes		Yes 2 No		
1 of Vital I	To Be	examiner?	2 No			ER/Outpatient	3 Do	A Oth	er: 4 Nursin	g Home 5	Residence 6 🗸			
_ = : ^ ≥		27. Manner of Dea 1 Natural 2 Accident	5 Pendir Investi		y,Yaar)	28b. Time of I FOUND: 1200 hrs		c. Injury at			now injury occurred bed and cut			
Division of Vital Into the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Place of		me, farm, stree	et, factory, o	office buildi	ing, etc.	28f. Location (S or Town, S 30 Deep Char	Street and Number tate) nnel Drive, Berlir	or Rural Route Number, City		
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier (Check only one) 2	Certifying Phy Medical Exam	vsician: To the best of niner: On the basis of example and manner state	xamination an	e, death occur d/or investigat	rred at the ti	ime, date a	and place, and ath occurred a	due to the cause at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)		
T W P	Me	29b. Signature and	d title of certifier	any manifer state	.u			License nu			29d. Date signed	(Month, Day, Year)		
OCME 10		30. Name and add	1/	who completed cause o					<u>.</u>			-		
	ate	Mary G. Ri 31. Date filed (Mo	<u> </u>	Deputy Chief Med	dical Exam		1 Penn S	Street, B	altimore, M	1D 21201				
Regis			APR 23	2008 Dilar	Sec. 10	Con	ALL!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 Year April 21, **Physician** 1:24 P M George Pappas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilcrest | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10/915/1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Turkey 177-30-7360 91 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryls nent of Health and Mental Hyglene.
ant; If Hean Z1 is marked other than "natural", or items 23a or 28a-f sho ant; If item 2 or other traumatic event, the "hedical Examina in mat 10 notified in 1 ☐ Yes 2 No MD Cockeysville Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 Court 2 B Lemon Grove Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/ Operator 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Delicatessen 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pappas, Sophia Aslanides Nickolas Xenldes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 B Lemon Grove Court Cockeysville, MD 21030 Despina Pappas 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important; If it any Injury or o one. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2008 Linwood, PA Lawn Croft Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760,2 Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 124 hours after death.

Reference of the Funeral Director: Aftered filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of-certifier APRIL 22, 2008 DI04395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST. SUITE 209 BALTIMORE. MO 21204 DOBETMAN, MD DANIEUE 31. Date filed (Month, Day, Year) State APR 23 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day} 20 APRIL **JAMES** AVIS PILKENTON 2008 12:35pм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ELLICOT CITY HOWARD 9394 PAULSKIRK DRIVE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 80 231 30 3126 02/09/1928 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner met be notified at Director HOWARD ELLICOTT CITY 1 ☐ Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PAULSKIRK DRIVE 9394 21042 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. WHITE 2 3 Nidowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 FORK LIFT MECHANIC PEMCO marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental UNK PILKENTON PEARL BOGGS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 9394 PAULSKIRK DR. ELLICOTT CITY MD. DALE A. DONALDSON/DAUGHTER 21042 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ō Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 Removal from State 4-23-2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) PARKWOOD CEM 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Lie AVE BALTIMORE, MD 21237 CHESACO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mouth disease or condition resulting in death) /Medical Due t (o) as a consequence of) Examiner terroscionan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the lirector, page 2 st 24a. Was an autopsy 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

Records, Division of Vital KENTON

4

or A To the Hospital within 24 hours a To the Funeral C

Director: After this certific I in by the funeral director, completely filled in by

Manner of Death 5 Pending investigation 2 Accident

6 ☐ Could not be 3 Suicide 4 Homicide

29a, Certifier

(Check only one)

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

555W. Towsentown Blud egistrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 0400 M April 21, 2008 Victoria C. Pasternak 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Esther's Place Assisted Living N/A Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 XF 86 Maryland 10728/1921 220-09-4769 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No Director N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2802 Pinewood Avenue 21214 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casimir Zimnoch Pauline Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Sniadach - Niece 18 Medici Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery | 04/24/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Licenses صند 401 S. Chester Street Baltimore, Maryland 21231 Part. Enter the disease, or complements that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parkinson y ears disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. This light cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ steoporosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Failure Be ည Certification:

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

burial-tran attending physician and the signed by the a the Hospital or Attending Physician: After this To the Funeral Director: completely filled by the within 24 hours a To the Funeral I

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Dementia.	lieur i di	1416		autopsy performed? 1 Yes 2	prior to completion of cause of death? 1 □ Yes 2 □ No					
25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special Property of the Control of the Cont								
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	3b. Time of 28 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	e, farm, street, factory	, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination	edge, death occurred an and/or investigation,	at the time, date and place, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)					

State Registrar

Medical

29b. Signature and title of certifier

MD

MIO

29d. Date signed (Month, Day, Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10WSON

lexander 31. Date filed (Month, Day, Year) APR 23 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician 20^{ay} 20ර්දී Sun Jung Pak 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** North Arundel Nursing & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 27,1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 215-88-7066 1 M XXF 83 Yrs S. Korea Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at MD Anne Arundel 1 ☐ Yes 2/☐ No Director Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be re-218 Cypress Ridge Drive 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hiller Important: If Item 27 is more any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yong Man Kim Bo Mul Hawng 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyung Yil Pak (Son) 218 Cypress Ridge Drive Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD |Meadowridge Memorial Park 4/23/08 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at 1 7250 Washington Blvd. Elkridge, Part. Enter the disease, or convications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma **Physician** Du to (or as a consequence of): cell CONK mthe /Medical Examiner Sequentially list conditions, if any, is admit to minimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t certificate Vagnal 2 Bleeding einia 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director: After ty filled in by the funera 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

Medical

31. Date filed (Month, Day, Year) 2 3 2008

29b. Signature and title of certifie

29a. Certifier

(Check only one)

313 HUSPITAL DR. GLEN BURNE, Md. 2106 KHANDELWAL HID 32. Aegistrar's Signature Solver

Mysician

and manner stated

Hending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

deli

DHMH 17 Rev 1/2001

29c. License number 0 2 9 8 7 3

29d. Date signed (Month, Day, Year)

04/21/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Deedent's Name (First, Middle Aart) **Physician** Apri 19 2008 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Memoria ltimore nion 8. Date of Birth (Month, Day, Year) 4- 20 · 193 | 9. Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Hours 218-26-8487 Yrs. Director Usual Residence of Decede Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene.

int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State iral", or items 23a or 28a-f show Examiner must be notified at 1 **X**es 2 □ No Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ronmenta 18. Mother's Name (First, Middle, Mai Father's Name (First, Middle, Be Bowler 19b. Mailing Address (Street and Number or Rural Route Number, 2518 W. Franklin St., Balf 19a. Informant's Name/Relations! Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State Moodlawn, 21. Signature of Funeral Service Licensee 5151 Total to. Nat'l Jule 23a. Part1. Entertible disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Artery /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 4 Unknown 2 No 3 Probably 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2 No 2 No 1 | Yes 1 ☐ Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 FR/Outpatient 3□ DOA 1 🗌 Yes 1 | Inpatient Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury To the Hospital or Attending 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19,2008 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Closk Amy NYC CIO lemorial

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

APR 23 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month ROBINSON Physician ANTHONY 0656 AM April 2008 D. 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore OF MARYLAND MEDILAL CENTER UNIVERSITY N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 XM 2 ☐ F MARYLAND Jun 15 1956 Director 218-64-1075 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show at 1 X Yes 2 No the Medical Examiner must be notified Director BALTIMORE 28a-f MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a U.S.A. 1208 GLENHAVEN RD. 21239 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Is marked other than Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. HOME IMPROVEMENT SELF 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DELORES B ROBINSON JOSEPH ROBINSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1208 Glenhaven Rd., Baltimore, Maryland 21239 Patricia Robinson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 X Buria 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 04-26-08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Linguises Moara 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final due to congestive heart failure overload chays **Physician** Volume disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner failure due to Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed Immunodeticiena Human that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Acquired Deticiency Immune Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, p.

within 24 hours after

To the Funeral Dire

completely filled in b

0 State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

PREET

SOUTH GREENE 32. Registrar's Signature

Bagi MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 3 2008

BAGI



🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

STREET

29c. License number AV417(0436B18128 (DEA)

1245432145 (NPI)

29d. Date signed (Month, Day, Year)

BALTIMORE MARYLAND 2120/

2008

08-03017 Kimberly Dawn	Rich				κ. Ensure All Copi Health and Mental H		ble.	
, ambony 2 a		1- For State	-	Certificate of L		Reg.	No 2006	3 1318
Physici	an/	Registrar 1. Decedent's Name (First, Middle, L	ast)	/		2. Date of Death	Day Year	3. Time of Death
Medical Exami	ner	Kimberly Do	LWN Richard	dson_		April 18, 200	08	0857 hrs
1		4a. Facility Name (if not institution, of 14 Chestnut Street	live street and number)		. City, Town, or Location of Deat Havre de Grace	h	4c. County of Death Harford	
Funeral Director			Sex 7. Age (In yr	s. last birthday)	If Under 1 Year If Under 24Hi Months Days Hours Mi	2	MM/DD/YYYY) 9. Birt	n
Director		2/4 -88 -60/5 1 Usual Residence of Decedent	M 2 F	% Yrs.		12-14	1-/96/ COL	intry) /(C)
any	ł	10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
and show	ᡖ	M) Har	Ford +	Havre de	Grace			1 Yes 2 No
Maryl - 28a-1	Director	10e. Street and Number	1 10 10	7 /	10f. Zip Code	10g	. Citizen of What Coun	try?
th the	<u>=</u>	40 ROBINI	rood Road, E	0x 705	21078		U.S.A.	
ath wi	Funeral	11. Marital Status 1 Never Married 2 Marrie		If Yes	Decedent of Hispanic Origin? (\$, specify Cuban, Mexican, Puerl		14. Race - Americ	can Indian, Black,
fler de	핀	3 Widowed 4 Divorc	1 Yes 2 Need If Yes, Give Year		es 2 No specify:		Specify: ///h	te
ours a	d by	15. Decedent's Education (Specify	only highest grade completed		Usual Occupation (Give kind of		6b. Kind of Business/I	ndustry
, 16 n 72 h n 72 h ical E	oleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	t of working life. DO NOT use re	eurea)	Disable	. 1
5-0036 led within 7. Hygiene. I other than	Comple	17. Father's Name (First, Middle, La	ot\	L	13abled	ne (First, Middle, Ma	2/10/00/1	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Tienn 27 is marked other than "natural", or items 23s or 28s-f show riranumatic event, the Medical Examiner must be notified at once.	Be C	William Va	1/0		Pattu	Coffn	,	
21; ould b d Men s marl tic eve	70 E	19a, Informant's Name/Relationship	(Type, Print)	19b. Mailing A	Address (Street and Number or			Zip Code)
MD id 2 sh ulth an m 27 i		Patty Mathe	Ny-Mother		Red Maple D	R., AbING	don MD	21009
9 - 4		20a. Method of Disposition 1 Burial 2 Cremation		b. Place of Dispositi crematory or othe	on (Name of cemetery, r place)	Date -	20c. Location - City or	Town, State
		4 Donation 5 Other Special		Bayview	Crematory 4	23-08	Baltimore	(MC)
Balti permit. Departr Import		21. Signature of Funeral Service kin	ensee	22. Na	me and Address of Facility	adley-1		eral Home,
Physician		23a. Part I. Enter the disease, or cor		ath. Do not enter the	mode of dying, such as cardiac	or respiratory arres		Approximate Interval
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, xaiiiiiei	- 1	or condition resulting in death)	Due to (or as a consequence	e of):				
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):				
	Examiner	(Disease or injury that initiated	c					
100 E ZE	EX	events resulting in death) Last	Due to (or as a consequence	e of):				
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'60, ate be	§ S	IF FEMALE:	23c. If yes, outcome of p		,4/23/00,W3		23d. Date of delivery	
Box 68760 e death certificate b the attending physi	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time or	f doath	death 3 Ectopic pregr	nancy	Month E	oay Year
Box e death the atter	ysic	1 Yes 2 No 9 V Unknow		othe	r (Specify)			
P.O. Be st that the digned by the		Part II. Other significant condition	s contributing to death but n	ot resulting in the un-	derlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords, P.O. w requires that the as been signed by t should be detach	ed by	Congestive hear	failure			1 Yes		ably 4 V Unknown
Cords Iaw requi has been	Completed					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
Recc The lar icate ha	E O					perform Yes 2		s 2 No
ital Recician: The scerificate	Be	25. Was case referred to medical examiner?	Hespital:		26.Place of Death (Chec	(only one)		
Division of Vital Records, tat or Attending Physician: The law requirers after death. "In Director: After this certificate has been sited in by the funeral director, page 2 should the	P	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient 28b. Time of Inju		ing Home 5 Re 28d. Describe ho	esidence 6 🗸 Other	: Scene
on on noting th.	ioi	1 Natural 5 Pending	(Month, Day, Year)	_	1 Ves 2 Tr No	unk	w injury occurred	
r Atter er dea rector	ficat	2 Accident Investiga	28e Place of Injury - 4		factory, office building, etc.	28f. Location (Str	eet and Number or Ru	ral Route Number, City
Divital or urs aft	Certification:	3 Suicide 6 X Could no determin	ot be	dence		14 Chestin	ut St. Havre	de Grace, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C		er:On the basis of examination		d at the time, date and place, ar	d due to the cause(s) and manner as state	ed.
To To com	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Theodo 111-	W: _ ~ / _	^	O.C.M.E. OCN	IE	April 19, 2008	
		/ / V VL - LU ///	11 (1		
1	-	30. Name and address of person wh	o completed cause of death (I	tem 23a)	·	<u></u>		

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

ORIGINAL

82. Registrar's Signature

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Doorstood of Doolth and Monthal Decisions	Department of neatural wenter hygener important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examin	once.
Division or Vital Records, P.O. Box 68760, 🔫	s Hospital or Attending Physician: The law requires that the death certificate be executed	E-principle and because the serial country of the property of the following the strength of the funeral director. After this certificate has been signed by the attending physician and property filed in by the funeral director, page 2 should be detached for use as the burial-transit	al

Medical faminer data in the Medical Examiner whether transmitted at the Medical Examiner data in the Medical family data in the Medical Examiner data in the Medi	Decedent's Name (First, Middle, Baldwin Rober Facility Name (If not institution Shady Grove Additions) Social Security Number 572-42-0831 Sual Residence of Decedent Fac. State 10b. County MD Montg. Fac. Street and Number 5803 Ogden Roa Marital Status 1 Never Married 2 Maria Shade (Specify only higher Elementary/Secondary (0-12) Father's Name (First, Middle, Baldwin Roberts Pa. Informant's Name/Relations Ann D. Roberts Ja. Method of Disposition 1 Burial 2 Marcemation	tson n, give street and num ventist Ho 6. Sex 1 M 2 F omery d 12. Was Decenared For Service Armed For 1 Yes, Give Year or Da it's Education of st grade completed) College (1-5+ Last) son	spital 7. Age (In yrs. Ia 73 10c. City, Beth dent Ever in U.S ces? 2 [2]No e ttes:	Yrs. Town or Leesda	Rock's If Under Months 10f. Zip 208 Was Decedif Yes, spect I Yes Sident's Usual Skind of woo DO NOT us	Code Code Code Code Code	If Under 24 Hours spanic Origin, Mexican, Specify:	Death Hrs. 8. D Min. Sei	ate of Birth Month, Day, 10t 26,	Monts (*eaf) 934 g. Citizen of SA 14. Ra Bla Speci	y of Death gomer 9. Birth Call What Cou	y place (State or Foreign ntry) 10d. Inside City Limits 1 □ Yes 2 □ No ntry? can Indian, etc.
taminer 4a. Sineral 5. Sector Usi	Shady Grove Ad Social Security Number 572-42-0831 Sual Residence of Decedent a. State 10b. County MD Montg We. Street and Number 5803 Ogden Roa . Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Never Married 2 Married 3 Never Ma	omery d 12. Was Decendence of the solution o	spital 7. Age (In yrs. Ia 73 10c. City, Beth dent Ever in U.S ces? 2 [2]No e ttes:	Yrs. Town or Leesda 16a. Dece (Give life.)	Rock's If Under Months 10f. Zip 208 Was Decedif Yes, spect I Yes Sident's Usual Skind of woo DO NOT us	Code Code Code Code Code	e If Under 24 Hours Spanic Origin, Mexican, Specify:	No. Septiment of the se	orth, Day,) Ot 26,	Monts (*eaf) 934 g. Citizen of SA 14. Ra Bla Speci	9. Birth Cali	y place (State or Foreign ntry) 10d. Inside City Limits 1 □ Yes 2 □ No ntry? can Indian, etc.
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19 200	Ann D. Roberts a. Method of Disposition	ship (Type. Print)					Mary M	1cCaff				
Jury or of		on/wife		5803	_	Roa			MD 20	-		
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ical Ex	equentially list conditions, any, leading to immediate ause. Enter Underlying ause. (Disease or injury at initiated events sulting in death) Last	Due to (d	or as a consequence as a consequence	ence of):								
for use a	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	come pf pregnan irth 2 Fetal ant at time of de wn	death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						ate of delivionth	very Day Year
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Completed				_				-	24a. Was an autopsy perform 1□ Yes 2		. Were aut prior to co death? 1 ☐ Yes	opsy findings availabl ompletion of cause of 2 No
To Be	5. Was case referred to medica examiner? 1	Hospital: 12fi 28a. Date of (Montal gation) not be 28e. Place		28b. Time of Injury	М	8c. Injur Worl	er: 4 🗆 Nurs	sing Home 28d. I	eck only one, 5 ☐ Residen Describe how cocation (Stre City or Town,	ce 6 00	ırred	ral Route Number,
Medical Co		ng Physician: To the Examiner: On the ba and mann	asis of examinati									
	Bb. Signature and title of certified with the company of the compa	publing.		23a) (Tuno]		e number	62				Day, Year)
m	NADHAVI HUS	314 9901	MEDIC	ML	CENT	ER.	DRIVE	ROC	icular	E M	ARY	AND 20857

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oszpin Day **Physician** ZOOK Year Woodword Reamond 3:00 A POIL 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DYroll HP5/01/21 moll Wesmins 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 16, 1915 Months Days Hours Min. 1X M 2□ F Maryland 93 Director 215-16-1945 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland| Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Bethany Lane 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WW I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Howard County Schools 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James F. Redmond Ella N. Strover ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gerald Fuller (Executor) 2947B Jessica Drive Winterville, NC 28590 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Mt. View Cemetery 4/24/08 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Haight Funeral Home & Chapel, P.A.

Moully P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructive pulmoner N:2632 **Physician** 12700 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tras Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 ☐ Innatient After this 27. Mann of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ann (Apel Mo vite 301 westminster 2115). 295

Registrar

State

31. Date filed (Month

32 Registrar's Signature

2008

Division of Vital Records. within 24 hours a To the Funeral L

> State Registrar

29b. Signature

Secry

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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28-35

DHMH 17 Rev 1/2001

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32. egistrar's Signature

29c. License number

D0053337

Sute 203 Baltimore, Md ZIZO4

29d. Date signed (Month, Day, Year)

4-18-2008

		1	For State Ragistrar	State of Mary		artment of Health an rtificate of Death		ene 	13185
A.C	Physicia	_	1. Decedent's Name (First, Middle, Last Charles Rodgers				2. Date of Death Month	Day Year	3. Time of Death 4:37 p. M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of C Takoma Park	04-18-0 Death	4c. County of Death Montgome	
E	. w' ⊇. ja ·		Washington Adve		pital yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	9. Birth	place (State or Foreign
3. 3	Funeral Director			^{3M 2□F} 58	Yrs.	Months Days Hours	Min. (Month, Day, 08-15-1		intry)
-	land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f sh	ctor	D.C.		ashingt	on			1 X Yes 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code		Og. Citizen of What Cou	untry?
	na 234	eral	25 R Street, NE	12. Was Decedent Eve	r in U.S. 13.	20002 Was Decedent of Hispanic Origin	? (Specify Yes or No-	S.A. 14. Race - Amer	
36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or terma 23a or 28a-f show event, the Modical Exertination and the contilled at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	SpecifBlac	
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121	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor			Private	
	il Hygie other	Ве Сс	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, M	Maiden Sumame)	
Maryland	should be Ind Mental Is marked o	ToE	Levi Wright		F		ine Rodge		in Codol
Mar	C/ C0 == 68		19a. Informant's Name/Relationship (T. Pearline Wright	_		street NE Wa			<i>ip</i> C000)
	item 27		20a. Method of Disposition	4	20b. Place of Disponentary, cre	osition (Name of matory or other place)	Date	20c. Location - City or	
Baltimore,	Page ment c ant: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) (-		d Cemetery 4-	The second secon		
Ball	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr QDCE.		21. Signature of Funeral Service Licens	Just	[1	2. Name and Address of Facility.	Ave. Balt	imore.MD	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of		death. Do not en	iter the mode of dying, such as ca	irdiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co		Shock			
	Examiner		Sequentially list conditions	s End	Stage	HIV/AI	DS		
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):				
<u>,</u>	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):				
8760,	eath certificate be executed attending physicien and for use as the burial-transit	cal	(d					
9	certifica ding pl	/Med	IF FEMALE:	23c. If yes, outcome of p	oregnancy			23d. Date of del	ivery
.O. Box	0 0	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
<u>a</u>	requires that the de sen signed by the a nould be detached f	þ	Part II. Other significant conditions of	ontributing to death but n	not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to es 2 ☐No 3 ☐ Pr	the cause of death?
Records,	s b	Completed					24a. Was a	24b. Were au	itopsy findings available completion of cause of
	The ate h page	Com					perfor	med? death?	2□ No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	Other	of Death (Check only or sing Home 5 Resid		out l
of	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time	of 28c. Injury at		ow injury occurred	City)
sior	ttending F death. ctor: After / the funer	catlo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 Tes 2 N		treet and Number or Ri	con I Pouto Numbor
Division of Vital	l or Ati after d Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	treet, factory, office	City or Tow	n, State)	urar modie ivaniber,
	To the Hospital or Attent within 24 hours after deal! To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of r niner: On the basis of ex and manner state	camination and/or i	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the of occurred at the time, o	ause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	MD		29c. License number	İ	29d. Date signed (Mont	
			115			60100		04-20-	
	3		30. Name and address of person who	ile RL	V10 5	ast Clay	of the	HUD 209	003
P.	St	ate	31. Date filed (Month. Day, Year)	32. Registrar's	s Signature	AP. a			
-	Regist	rar	APR 23 2008	process.	is upon				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8:00 A M Limothy 08 /Medical 4a. Facility Name (If not institution give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Avenue 2900 Boarman Itimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min 61 211-50-6380 **Director** MI Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 Pres 2 No Director Himore MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4710 Schler 21206 Funeral enue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 4 If Yes, Give Year or Dates: 2 4 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Blyck permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, To Be Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Beverly Sweetwine -21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Batto, 4 ☐ Donation 5 ☐ Other (Specify) 23 21. Signature F neral Service Lice Joseph 2222 North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AS CVI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 2□No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) examiner'i 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death funeral 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
APR 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5010. YORK Rd.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Balto. mg.

29c. License number

D7-8766

29d. Date signed (Month, Day, Year)

4/21/68

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per th 8878 4-25-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 04 **Physician** 20 2008 2:25p M Sinclair Sr. David Kina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, O 6 29 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Year) 1**X** M 2□ F 250-10-9411 SC Director 88 Usual Residence of Decedent 10a State 10h Counts 10c City Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Howard Columbia 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 10356 Triple Feather Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Yes 2-14If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: 2 Specify: 3 □XVidowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Armed Forces Maintenance Operator other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Sellers Sam Joe Sinclair မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10356 Triple Feather, Columbia, Md 21044 Thomas_Sinclair-Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 0 Important: If any Injury o Garrison Forest Vet 4/29/080wings Mills, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee pson 21215 Ihom 23a. Part. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

METASTATIL COLON CIMCEN Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl o e Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🐒 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To HOSPICE Manner of Death
Natural
Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0055532 64, 21, 2008

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of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

SHALART, 40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Apri 1125PM 2008 4c. County of Death or Location of Death imo MEMOR 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Min 1 M 2 M Yrs. 10d. Inside City Limits 10c. City Nown or Location 10b. County 1 res 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21202 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Specify B/Ack 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OwnHomic FWI 18. Mother's Name (First, Middle, Maigen Surnam 17. Father's Name (First, Middle, Last) Sommers 19a. Informant's Nanie/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21206 20b. Place of Disposition (Name of 20c. Location - City or Town, State Method of Disposition 1 Description Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) re of Funeral Service Licenses at caused the death. Do not enter the mode of dying, such as cardiac or re on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus

Physician /Medical

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Box 68760, ←

P.O.

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Division or Vital

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10a. State

Funeral Director

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Immediate Cause (Final disease or condition resulting in death)

Examiner

attending physician and for use as the burial-tran detached page 2 should

law requires that the death certificate be executed the Ś been signed be should be deta certificate has or Attending Physician: director, within 24 hours after death.

To the Funeral Director: After this funeral completely filled in by the To the Hospital

> State Registrar

Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 2 No Hospital: 1 Impatient 1 Tes 2 ER/Outpatient မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 2 Accident 6 □ Could not be 3 ☐ Suicide determined 4 | Homicide 29a. Certifier Medical 29b. Signature and title of pertifier

Le to r as a consequence of):

3□ DOA

Injury

28c. Injury at Work?

3 Ectopic pregnancy

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 ☐ Unknown

24a. Was an

1□ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one

autopsy performed? Yes 2☑No

28d. Describe how injury occurred

23d. Date of delivery

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ¶o

Day

Year

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 0 00631 63

29d. Date signed (Month, Day, Year) April 21,2008

Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address ...

Union memorial thespital, 2018 est University Parking Baltistare Maryland

31. Date filed (Month, Day, Year) APR 2 3 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1:20 PM Stokes 2008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Daltimore MD owsm If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) . Social Security Number **Funeral** Days Hours 1 □ M 2 🗗 F 49 Months 218-74-7131 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanirer must be recitled at any injury or other traumatic event, the Medical Evanirer must be recitled at any injury or other traumatic event. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Baltimore Wordlawn Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number USA Brook 21244 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status □Yes 2 □N 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □NO Yes. Give Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) redit 4415 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geral 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (His band) Brook Ct. Wordlawn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method Disposition Park 4/23/08 Baltimore, Mp

22. Name and Address of Facility loughn & Greene Feneral Str

5151 Balto Natil P. Ke Balto. MD. 21229 1 Lourial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License T. Take Valdre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) PANCREATIC CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Y Other (Specify) Hospital: 1∐Yes 217 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29da Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar

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TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. ERNESTINE WRIGHT

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APPLO 11147/5, per H. CS/8, 4/23/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** JESSIE SKINNER-FULLER 1:15 P M APRIL 17, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 6701 WILMONT DRIVE, APT. #104 GWYNN OAK If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 4/30/1929 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**X** F ARKANSAS Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No GWYNN OAK Director MD BALTIMORE the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with: 1 and Mental Hygiene. 1s marked other than "natural", or Items 23a or 2 USA 21207 6701 WILMONT DRIVE, APT. #104 Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any fnjury or other traumátic event, the Medical any fnjury or other traumátic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9TH College (1-4or 5+) HOUSEKEEPER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLEMIE FOSTER HOSA WALLACE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6706 WINDSOR MILL ROAD, BALTIMORE, MD 21207 GWENDOLYN WIMBREY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CATONSVILLE, MD METRO CREMATORY 4/24/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Approximate Interval Between Onset and Death e, or complications that caused the death. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest. the disea immediat use (Final **Physician** disease ondition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed bunial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions dontributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 2 No 24a. Was an has autopsy 2 No Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 Tyes 1 🔲 inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 XNaturai 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier red cause of death (Item 23a) (Type ne and Registrar's Signature 31. Date filed (Month, State 23 Registrar 2008

DHMH 17 Rev 1/2001

ORIGINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) APRIL 19 2008 9:20 ам **Physician** PAUL SCHAPER JR. WILLIAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ROSEDALE WOODHAVEN ROAD 8131 8. Date of Birth (Month, Day, Year) 5 / 12 / 1927 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Funeral Months Days 1 ☑ M 2 ☐ F 80 MARYLAND 218 22 1965 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 XNo iral", or items 23a or 28a-f sh Examiner must be notified BALTIMORE ROSEDALE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or ant; if item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be r 21237 USA 8131 WOODHAVEN ROAD Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🔀 No Specify: Specify: Baltimore, Maryland 21215-0036 þ WW II 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MOTOR COACH CHAUFFEUR 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be NOLLMEYER SCHAPER Sr. MARIE WILLIAM Ρ. P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA ANN SCHAPER/WIFE 8131 WOODHAVEN ROAD BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or of once. 1 El Bunal 2 Cremation 3 Removal from State 4 Donation 5 A Other (Specify) ENTOMEMENT GARDENS OF FAITH 4/23/08 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee CHESACO AVE BALTIMORE, MD 21237 1211 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LON 01 Physician 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MISNA FALWRE Examine the Hospital or Attending Physician: The law requires that the death certificate be executed stcian and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No a I Inknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ANTIMETIS (50 3 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s perform 1☐ Yes 2 1 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.
I Director: After this ceed in by the funeral director. 1 ☐ Yes 1 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c, License number (Check only one) and manner stated 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier daath (Item 23a) (Typa, Print) 10 30. Name and address of person who completed 1991

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State Registrar 31. Date filed (Month, Day, Year)

32. Aegistrar's Signature

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ĺ	20a. Method of Disposi	tion		20b	. Place of Dispo	sition (Nam	e of cen	netery,		Date	20	c. Location	- City or To	own, State	
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Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis.	Dhyeirian/Mad	IF FEMALE: 23b. Was decedent pre	egnant in the		s, outcome of pre e birth		Fetal death	3	Ectopic	c pregna	ancy		Month	-	ay	Year
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P.O.	<u> </u>	Part II. Other signific	ant condition	ns contributin	g to death but n	or resulting in th	e oncenying	9 00000	9.70		1	Yes	2 No	3 Prob	ably 4	Unknown
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	completely filled in by	4 V Homicide	determ		ify) Townho					-			Street, Ba			
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		290. Signature and the	./,	7/				0.0	C.M.E.	U	OME		April 22	, 2008		
		30. Name and addre	ss of person i	who complete	ause of eath	(Item Za)										
10		Theodore M.			istant Medic	cal Examine	111 F	enn S	Street, B	altimo	re, MD 2	1201				
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Registrar

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State of Department of Health and Mental giene

Certificate of Death

Reg. No.

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dical Exami				e street and number)		4b. City, Town, or	Location of E	Death		County of		
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Funeral Director		5. Social Security N	4 516 ₁ X	ex 7. As	ge (In yrs. last	Yrs	Months Day		1.6	3/09/19		Foreign	Myngton, DC
any		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, To	own or Loca	tion					1	10d. Inside City Limits
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farylar 28a-f s	Director	10e. Street and Nu	umber				10f. Zip Code				citizen of W		
vith the Maryland s 23a or 28a-f show a e notified at once.	D.	43 Seafa	arer Lane			- F40 114	2181 as Decedent of Hi		2 / Specify Y		ted S		an Indian, Black,
th with	Funeral	11. Marital Status 1 Never Marr	ried 2 Marrie	d Armed Forces	2	lf '	Yes, specify Cuba	n, Mexican, F	Puerto Rican,	etc.)	Whi	te, etc.	
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2 21 Should and Me	ို		Name/Relationship				Ponds W						
and 2: fealth 2 tem 27		20a. Method of Di			L.	lace of Disprematory or	osition (Name of c	emetery,	Date	9 20	Oc. Location	- City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygens I happer ant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trannatic event, the Medical Examiner must be notified at once.			X Cremation 3	Removal from	State Ba	yview	Cremato	ry	04/21/	2008 B	altim	ore,	Maryland
altin mit. P partme portar ury or		4 Donation 21. Signature of F	uneral/Service Lic	ensee	м01113	22	Name and Addre	ss of Facility	Raymo	nd Fun	eral	Serv	ice, PA
	_	und	THE	nplications that caus	ed the death	Do not ente	635 Wash:	g, such as ca	AVEITU	iratory arrest,	shock, or h	neart	Approximate Interval
Physician /Wedical		failure. List 3	one cause on	each line. a. Hypertensive									Between Onset and Death
tamine		Immediate Cause or condition resu	- 1	Due to (or as a co									
•	Ļ	Sequentially list of if any, leading to	conditions,	b	nsequence of	7):							
	mine	cause. Enter Un (Disease or injury	derlying Cause	c									
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and formation of the first of the function and the certificate has been signed by the attending physician and the property of the first of the	edical Examiner	UNPENDE	ED :		1 Per 1	ME G87	8 4/28/0)8 JH/	/#1,perl	Æ,G878,4			
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Records, The law require ficate has been s	1									perform 1 🗸 Yes 2	ed?	death?	
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Divisior To the Hospital or Attend within 24 hours after death. To the Functal Director:			Certifying Phy	rsician: To the best	of my knowled	dge, death o	ccurred at the time	e, date and pl nion, death o	lace, and due ccurred at th	e to the cause e time, date a	(s) and maind maind place, a	nner as st nd due to	ated. the cause(s)
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	*	101	The M	eu r	LP		0	.C.M.E.			April 14	, 2008	
XXX				who comp sted cause	of death (Iter	m 23a)	44 D 01	et Delline	oro MD o	21201			
10x 10			reenberg MD.	Assistant Me	edical Exar gistrar's Signa	ture	11 Penn Stre	et, Baitim	ore, IVID 2	. 1201			
Reg	Stat istra	e or Date filed (A	APR 23	2008	يكر مساولات	y A	and .						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Doris Elaine Settino 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1927 Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 1 □ M 2 🖺 F Pennsylvania 141-22-9634 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Prince George's New Carrollton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 7603 Vicar Place 20784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Blackburn Charlotte Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6519 Adelphi Rd., Hyattsville, MD 20782 Pamela J. Wilkerson, Daughter 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/24/2008 Silver Spring, MD Gate of Heaven Cem. 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Cons Hyattsville, MD 20781 ase Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on anch line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl Completed by s certificate has be irector, page 2 s Be director Certification: To this After Medical

Physician /Medical Examiner

within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1 Natural 2 ☐ Accident 3 ☐ Suicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be 4 Homicide

28a. Date of Injury (Month, Day Year)

28c. Injury at

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🛮 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

29c. License number

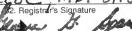
29d. Date signed (Month, Day, Year)

MD. 8118 Good Luckld, Lanham, MD.

State Registrar

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31. Date filed (Month, Day, APR 2 Year) 2008



Please Type or Print in Black Indelible Ink, Epsure All Copies Are Legible. amend item 1 per doc, 18 per fh 8879 5-5-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Adam G. Schlosburg Day Month **Physician** Porul 0527R" 16 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore The Johns Hopkins Hospital N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 04/01/1975 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 213-11-7377 33 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 123 STRONGWOOD ROAD USA 21117 death v Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) traumatic event, the KITCHEN DESIGNER HOME DEPOT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **SCHLOSBURG** DAVID RANDY ASRICAN ASTRI ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trai DAVID SCHLOSBURG / FATHER 123 STRONGWOOD ROAD, OWINGS MILLS, MD 21117 Pages 1 a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BETH EL MEMORIAL PARK 04/18/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 6 days /Medical Due to (as a consequence of): Examiner Asolration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of): Examiner Dustonia Due to (gr as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 0 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 27 1 Tyes 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autope perforr Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 ER/Outpatient 3 DOA 2 Inpatient Manner of Death Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗜 🗲 📞 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 April 16 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North wolte steet Baltimore taryland Hospital Amy DeZero
31. Date filed (Month, The Johns Hopkyns egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year **Physician** APRIL. **JEANETTE SCHATOFF** 20 12:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3310 BENSON AVENUE, #419 BALTIMORE N/A | Tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Min. | 09/22/1920 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔏 F 212-20-9513 87 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanimer must be notified at MD N/A BALTIMORE 1 X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" or the any injury or other traumatic event. 3310 BENSON AVENUE, #419 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐Yes 2 🕅 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No WHITE Specify: 2 Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** GARMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **TOBESMAN** UNOBTAINABLE HARRY IDA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JACK SCHATOFF / SON 5698 MINERAL HILL RD., ELDERSBURG, MD 21784 20b. Place of Disposition (Name of Cameter, crematory or other place)
MD FREESTATE POST 167
JEWISH WAR VETERANS 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State MD 4☐Bonetion 5 ☐Other (Specify) 04/22/2008 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 🗆 Yes 2 No 3 Probably 4 Unknown this certificate has been sal director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Hospital or Attending Physiclan: The 24 hours after death.
Funeral Director: After this certificate hately filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. To the within 2 29b. Signature and title of certifies Maiden Choice La. Catonsvill MDZINS ss of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}8 **Physician** APRIL 2008 JOSEPH 3 1 STEIN 2:57 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MD 83 220-14-6454 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 7428 KATHYDALE ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 □Yes 2 No Š 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **EDUCATOR** EDUCATION 2 should be filed win and Mental Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEIN WEINSTOCK BESSIE LOUIS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SANDRA STEIN / WIFE 7428 KATHYDALE ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 04/22/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Immediate Cause (Final Physician P515 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner E. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Exami Due to (or as a consequence of) attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLU 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27, Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

death with

within 72 hours after

Baltimore, Maryland 21215-0036

10

State Registrar

Medical

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

V. Charles ST TOWSIN MD 21204 W

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only

APR 23 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2008 6:45 A April Robert Alan Spar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 6070 Avalon Drive Elkridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **X** M 2 □ F 44 New York 111-54-3938 20, 1963 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b County 10c, City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examiner must be notified at 1 ☐ Yes 2 XNo Director Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 United States 6070 Avalon Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 N Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify. 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) and Mental Hygiene. Law Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phyllis Kruh ပ Vincent Spar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 6070 Avalon Drive, Elkridge, Maryland 21075 Anne M. Spar - spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 17, 2008 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory M00053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licenses M. Dieka MMP., Inc 7250 Wash. Blvd., Elkridge, MD 21075 1614 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - 4 week Mcemba disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Caranomatasis metastatic asdomina Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Inte TICTRO burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending pl for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy nerforme certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

15

State Registrar Michaela Higgins, MD, 31. Date filed (Month, Day, Year)

APR 23 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weinberg Bldg., 401 N. Broadway, Baltimore, MD 21231

DHMH 17 Rev 1/2001

AT4147357

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** RE ROUTOMAN :COAM 2008 15 MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5 OWA AND A OURT If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1□M 20F Country) GLAND Hours Min Director sidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 20...-any injury or other traumatic event, the Martin. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code BALTO Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes M No Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 C 19a. Informant's Name/Relationship (Type. Print) STEVEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 ☐Removal from State 1☐Burial 2 ☐Cremation 4 ☐ Donation 5 ☐ Other (Specify) 10N 21. Signature of Funeral Service License 22. Name and Address of Facility mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final PINEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician a Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a Ö 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS DIABLIES Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an MOISHSTASAPH The law autopsy performed? Yes 2 2 No page 2 s has DEMENTIA certificate 1☐ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No dea h. 2 Accident within 24 hours are dear To the Funeral Director completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Dav. Year) MYSICIAN 29b. Signature and title of certifie 42723 2008 MARCH RANDALLITOWN COURT RACI SUITE 303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERAHALLI M KARISH. 21133 AVYERAHALLI 31. Date filed (Month, Day, Year)
APR 2 3 2008 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 Year April 21, **Physician** 11:28 AM Denise Taurino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 2022 Cambridge Drive Crofton if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea March 2, 1 5. Social Security Number **Funeral** Months Days Hours Min. 1 M 2 X Yrs ı̈̃951 57 190-42-6144 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21114 2022 Cambridge Drive Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 System Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cosimo Taurino Eleanor Ader 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Carr/Daughter 2022 Cambridge Drive, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2008 Alexandria, Virginia Robert E. Evans Funeral Home Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No been signed by the should be detached Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Żunknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) D5525 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lee Drite Elkridge, mo iwilks 31. Date filed (Month, Day, Year)
APR 2 3 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEN THE 1 - For State Registral Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician 91 ପ୍ତ 0610AM April non 200% /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Health altimore nes Lare 8. Date of Birth Month, Day, rity Number 7. Age (In yrs. last birthday)
Yrs. If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X**F Months Davs Hours Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Mes 2 No Director timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Deceden's Usual Occupation (Give kinkt of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Number al Ro<u>ute</u> Number, mo alaag Fland Mem Baltimore SOM innard(20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 3 Removal from State timore, and 4 □ Donation 5 □ Other (Specify) vre of Funeral Service Licer See Vaughn G. Greene 21. Signal Balto. Nat'l rilce. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or hear failure. List only one cause on each fine.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia Approximate Interval Between Onset and Death **Physician** Zominutes /Medical Examiner ypertaleny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform ta 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 1 | Inpatient 2 EN Outpatient 3□ DOA Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I 1 Detritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Tang 900 S. Caton Ave Baltimore imb . Registrar's Signature 2 3 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:10 PM 21,2008 April Nicholas K. Taliadouros 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City Joseph Richey Hospice
Social Security Number 6. Sex 7. A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 9-4-1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 F Yrs. 374-38-2009 Greece 72 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Xes 2 ☐ No Baltimore City Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 716 S. Ponca Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painting Painter 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kaliopi Amorgiganos Klevoulo Taliadouros 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 S. Ponca Street, Baltimore, MD 21224 Maria Vela - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Oak Lawn Cemetery 4-24-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licen PA, 2134 Willow Spring Rd., 21222 MO1455 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) with Lyver T Brown Due to (or as consequence of): 4 mo Concer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 22 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 🗹 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Many of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

+ DOWROS The law requires that the death certificate be executed Records, という Division or Vital To the Hospital or Attending Physician: 24 hours after death e Funeral Director:

Examiner Physician/Medical Completed by Be Certification: To Medical

Physician

/Medical

Director

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Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical **Examiner**

Baltimore, Maryland 21215-0036

death with the Maryland

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

D06070, Alsry (2n)

29d. Date signed (Month, Day, Year) 22, 2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) w. Lake

1 Biltimor MD 21210-1303

State Registrar

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	-	For State		epartment of Health and I Certificate of Death	Mental Hygien	
		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physic	ian				April 20,	2008 3:30 P. ^M
/Medi		Edwina Anna Thrift 4a. Facility Name (If not institution, give s	treet and number)	4b. City. Town, or Location of Death	1	c. County of Death
Exami						Carroll
		Longview Nursing House 6. Sex		Manchester day) ff Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Funeral		1	M 2XX 81 Y	Months Dave Hours Min	Jan. 30,	Country) 1927 Maryland
Director		218-22-6032 Usual Residence of Decedent	81		Juaii. 207 1	1927 Haryrana
and		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
ehow	5	v 1 1 011	T-7	-t		1 ☐ Yes 2 📆 No
78 8 - 88 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	ect	Maryland Carroll 10e. Street and Number	Westmin	10f. Zip Code	10a, C	itizen of What Country?
di vi	늅		_		Uni	ted States
ING Z1Z13-UUSD be filed within 72 hours efter death with the Maryland tal Hygiene. d other then "natural", or items 23a or 28a-f show event, the Madical Exeminar must be nutitied at	Funeral Director	5200 Band Hall Hil		21158		America 14. Race - American Indian,
er de	une	11. Wantai Olalas	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S ff Yes, specify Cuban, Mexican, Puer 	o Rican, etc.)	Bfack, White, etc.
S eff	by F	1 Never Married 2 Married	1 ☐ Yes 2000No If Yes, Give	1 ☐ Yes XXNo Specify:		Specify: White
in i	0	\$\frac{1}{2}\text{Widowed 4 \subseteq Divorced}	Year or Dates:	Decedent's Usual Occupation	16h	Kind of Business/Industry
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Maryiand 21215-UUSD td 2 should be filed within 72 hours ef th and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, the Medical Exam		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or R		
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or He strain		20a. Method of Disposition 1 X Surial 2 Cremation 3 F	20b. Place of I	Disposition (Name of crematory or other place) On Forest Ap		Location - City or Town, State
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Baltimore, permit. Pages 1 ar Department of Heal Importent: It item: any injury or other	1	21. Quature Full let Se, vice is sus	90	22. Name and Address of Facility Eckhardt Funeral (
Balt permit. Depart Import	4 1	(Santo Bennaut	y .	3296 Charmil Drive	Manchest	er, Maryland 21102
		23 Part Enter the disease, or comp	cations that caused the death. Do no	ot enter the mode of dying, such as cardia		Approximate Interval Between
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Division of Vital Records, to Attending Physicien: The law requires taller death. Director: After this certificete has been signs in by the funeral director, page 2 should be.		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. T		28d. Describe how in	
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Div Alor A after 1 Direct	Certification:	4 Homicide	building, etc. (Specify)		3.,, 3. 10	
Hospital 24 hours of Funaral stely filled		29a. Certifier 1 Certifying Phy	vsician: To the best of my knowledge	, death occurred at the time, date and plan	ce, and due to the cause	e(s) and manner as stated.
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exam	iner: On the basis of examination and	d/or investigation, in my opinion, death oc	curred at the time, date	and place, and due to the cause(s)
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17)	tate	31. Date filed (Month, Day, Year)	2 Fon MD 3337	Victory Street	Maneh	Days signed (Month, Day, Year) 121 2003 esfer MD21102

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

APR 23 2008

Charles Benner, MD, 10801 Lockwood Drive #205, Silver Spring, Md 20901

2. Registrar's Signature

nd Rutedge		I- For State	State	of Maryla		tment of ificate of	Health and Death	Mental Hy	rgiene Reg.	No. 21	201	1326
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hour after ceath. To the Funeral Director: After this certificate has been signed by the attending physician placed by the funeral director, page 2 should be detached for use as the browness.	Physician/M	past 12 months?			oirth nant at time of dea	uh - =	tal death 3 L her (Specify)	Ectopic pregna	ancy	Month	Day	Year
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LIVI To the Hospital or within 24 hour, afte To the Funeral Dir completely filled in	Medical	(Chank ank)	tifying Physici dical Examiner	On the basis	of examination ar	je, death occur nd/or investiga	rred at the time, da tion, in my opinion,	te and place, and death occurred	at the time, date a	(s) and manner and place, and du	e to the caus	se(s)
To To	Mec	29b. Signature and title		and manners	stated.		29c. License			29d. Date signed		
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01		30. Name and ddress Margarita Kore			se of death (Item dical Examin		enn Street, Ba	altimore. MD	21201			
S	tate	31. Date filed (Month D		B	egistrar's Signatu	193	1. 2	,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Day **Physician** 7:19 PM /Medical Facility Name (If not institution, give street and number) or Location of Death City, Town, 4c. County of Death Examiner ttimore If Under 24 H 7. Age (In yrs. last birthday, Birthplace (State or Foreign
 Gountry) **Funeral** Hours Davs 1□M 2♥F Vrs ar Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evander and be notified at once. 1 X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🕅 No Specify <u>م</u> 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) (Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City/or 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility
Joseph L. Russ
2222 W. North uneral 11 21. Signature of Funeral Service Licensee Ave. 23a. Part 1. Enter the chease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart finding. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 2ertension sician and burial-trans (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 C Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 1 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 27, Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be

Division of Vital Records, P.O. Box 68760

Ratera Williams

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Baltimore, Maryland 21215-0036

Pages 1

The law requires that the death certificate be execute Hospital or Attending Physician:

in 24 hours after death.

the Funeral Director: After this certific haletely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director director directors and the funeral director directors and the funeral director direct

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3 Suicide

29a, Certifier (Check only one)

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State Registrar	1	i.	
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin A. BARBUL - SINAI HOSPITAL -	2401WMELVEDERE	AUE, MACTURAL, 4
vith Volume	29b. Signature and title of certifier Soulul My	29c. License number D 2 2 2 5 4	04/20/2008

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fogmend #27 Per Phy g878 4/23/08 Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year WOLTZ **Physician** KUSSELL 10TH 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** REGIONAL HOSPITAL COUNTY AUREL TURF If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F **Director** 579-12-6345 88 March 15, 1919 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 ☑ No Director Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 USA 406 Laurel Ave Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Black, White, etc. hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nat any finury or other traumatic event, the Medica any fulury or other traumatic event, the Medica (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Westinghouse Glass Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Oscar Woltz Betty Watts 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Woltz- son 406 Laurel Ave., Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory March 13,2008 Alexandria, Virginia 22. Name and Address of Facility Fleck Funeral Home, 21. Signature of Funeral Service Licensee INC. M01234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LNTRACRANIA /Medical Due to (or as a consequence of): Examiner YPERCAPNEIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed YPERTENSION as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 2 No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XXatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ould not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier X-COY 500 YSICIAN

Registrar
DHMH 17 Rev 1/2001

State

. Name and address of person who completed

31. Date filed (Month, Day, Year) APR 2 3 2008

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HOSPITALIST

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Registrar's Signature

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W- '	ral Exami	ner		ouglas	Young							Month April 15,	2008		1640 h	rs
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	Funeral		5. Social Security		6. Sex	7. Age (In yrs	s. last birthd		f Under 1 Yea	r If Unde	er 24Hrs.	8. Date of B	irth(MM/DD/YY	(Y) 9. Bi	irthplace (State	e or
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	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	은	19a. Informant's N	lame/Relations	ship (Type, Print)			-					umber, City or T			0
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	Bal permi Depa Impo		21. Signature of F	w Da	/	1234		Flee	k Funera	al Hom	e, IN	C.	MD 2070	7		
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P	_Aaiiiiiei		or condition result	ting in death)	Due to (or as	a consequence	e of):				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	/Mec	IF FEMALE:	t progrant in t	he l	, outcome of pr	regnancy		_				23d. Date			
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	Division of Yor the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		29a. Certifier (Check only one)	Certifying F	hysician: To the basi	est of my know	rledge, death on and/or inv	h occurred	d at the time, o	date and pl	lace, and ccurred a	due to the ca	iuse(s) and mar te and place, ar	ner as si d due to	tated.	
	To th withi To th	Medical	29b. Signature an		and manner	stated.			29c. Licen						Month, Day, Ye	ar)
			hi		mp					.M.E.			April 16,			
			30. Name and add	<u> </u>	n who completed ca	use of death (I	tem 23a)				-					
	3		Ling Li, MD		ant Medical Ex			Street,	Baltimore,	MD 212	201					
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State of Maryland / Department of Health and Mental Hygiene. UUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 9:33 AM Aster T. Aregay 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MICOMA Marit Comer) MASHICON BUCKTIT HURIM SYZK If Under 1 Year II Under 24 Hrs. 7. Age (In yrs. 73 8. Date of Birth (Month, Day, June 12 Birthplace (State or Foreign Country) 5. Social Security Number last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🕅 F 579-19-5227 ,1934 Ethiopia June Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. ? is marked other than "neture!, or items 23a or 28a-f ebov treumatic event, the Machical Experiment near by natified at 1 Tr Yes 2 □ No Director MD Prince George's Mt. Rainier the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20712 Ethiopia 3111 Arundle Rd. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠ No II Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental Fire marked of bs 1 and 2 should b of Health and Ments fitem 27 is marked r other treumatic e Workue Tekele T. Aregay Abaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sergout Workue/Daughter 3111 Arundle Rd., Mt. Rainier, MD 20712 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Ft.Lincoln Cem. 4/2/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln F. H. 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 Littani 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATKROSCHERAC CARLW VASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner s and the state of Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 € tonknown been sig 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page certificate 1 TYPS 20 100 Physicien: director 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 20 No 2 R/Outpatient 2 3 DOA this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending Unours after death. Unerel Director: All sly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ö within 24 hours a To the Funerel I Hospitel Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 3542 03-31-2008 SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month

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Box 68760.

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Division of Vital Records,

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32. Registrar's Sign

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0	Physici	an	1. Decedent's Name (First, Middle, Last) Oliver David Akers				2. Date of Death Month April 11	Day Year	3. Time of Death 2:50 P M
r s	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		DLII II	4c. County of Deat	
	Exami	lei	19508 Piney Point Road			ey Lee		St. M	[ary s
e.	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. In the second of the secon	last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, May 31,	Year) 1936 Wes	hplace (State or Foreign untry) t Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo	cation				10d. Inside City Limits
	ne Maryla 8a-f sho stified at	ector	Maryland St. Mary's		Valley L	ee	146	0.00	1 □Yes 2 No
	th with th	Funeral Director	19508 Piney Point Road		10f. Zip Code 20692			g. Citizen of What Co USA	
212-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ODEs.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes, Give Year or Dates:		Was Decedent of Hispa f Yes, specify Cuban, N 1 □ Yes 2½ No S		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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פר	al Hygi other vent, 1	Še Č	17. Father's Name (First, Middle, Last)		18.	. Mother's Name	(First, Middle, N	faiden Surname)	
yıand	Menta Merita arked aric ev	To E	George Earldon Akers				Nannie N		
, Mar	and 2 sho saith and 1.27 is ma er trauma		19a Informant's Name/Relationship (Type. Print) Marneda K. Grable / Daughter		ig Address (Street and illon Drive				Zip Code) 1, VA 23452
more	Pages 1 sent of He nt: If Item		1 Duriel 0 El Cremetion 2 Demouel from State	emetery, cren	sition (Name of matory or other place) n Crematory	Apri1	15	20c. Location - City or Alexandria, V	
baitimor	permit. Departm Importa any Inju		21 Signature of Fuheral Service Kidensee	22	2. Name and Address o Mattingley-G P.O. Box 270	f Facility ardiner F	uneral Hom	ne, P.A.	
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	Vithi To th	Ň	29h Signature and title of certifier		29c. License nu		29	9d. Date signed (Mon	
	- na		Vo JM Turns)	- 00-) (T	- '/'	285		4-14-	-08
6	Dr -		30. Name and address of person who completed cause of death (Iten William D. Boyd, II, M.D. 25,365 Poin	t Lookov	it Road I nor	nardtown.	MD 20650		
	Sta Registi		31. Date filed (Month, Day, Year) 5 2008 32. fegistrar's Signa	ture A	porte	.ar acowii	_ 20050		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 13 Day 2008 ear **Physician** 12:15 PM Edith Mae Albright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dove Hospice House Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec. Month Day 1924 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 TF 83 Virginia 212-76-7577 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits X□Yes 2□No Maryland Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or İtems 23a or Examiner must be 415 West Washington Street 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rthan Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 Is marked other than Food Service Worker Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elishie Eppa Suthard Estell Alice Heflin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 21019 Tasker Lane, Boonsboro, MD 21713 Christopher W. Albright, Hus. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Apr. 18, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litensee ²² Name and Address of Facility Keeney and Basford PA Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Screen (First) Immediate Cause (Final SEMENTIA STAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-tra Due to (or as a consequence of) Box 68760 physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed peen PIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performe certificate 1∐ Yes or Attending Physician: 25. Was case referred examiner? medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HEVE 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural within 24 hours after ucc...

To the Funeral Director: Aft 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 299 Date signed (Month, Day, Year) 29b. Signature and title of certi

State Registrar

DHMH 17 Rev 1/2001

Couter Stroot (NOSTMILLSTON, MD2115)

21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

V

31. Date filed (Month, Day, Year)
APR 2 3

	-	- For State Registrar	State of M	larylan	-	artmer <i>rtificat</i>			and M	ental Hy	gien Reg. N	700	8	13212
vojojo		1. Decedent's Name (First, Middle, Las	t)					_		2. Date of De		ay Ye	ar	3. Time of Death
nysiciar Medica	1	Catherine Louise								Month 3/	31/	2008	<u>"</u>	12:00 a M
kamine	r	4a. Facility Name (If not institution, give						Location o	f Death			c. County of D	_	1
		South River Heal 5. Social Security Number 6. Se			to at 6 table days		ewate		Od Wro T	0.0-1(0)		nne Arı		
neral ector				84	last birthday, Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 9 / 10	ay, Yea <i>i</i>	r)	Countr	
ACT.		Usual Residence of Decedent								9/10	/19	23		VA
Be Completed by Europea Disorter		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							100	d. Inside City Limits
1	Ulrector	MD Anne Aru	ndel	Sha	dy Sid	le								1 □ Yes 2 No
غ ا	<u> </u>	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What	Countr	y?
		4902 Mariner Driv	7e					20764	1			U.S.A	Α	
2	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Dece If Yes, spe	dent of H	ispanic Orig	gin? (Spe , Puerto F	cify Yes or No Rican, etc.))-	14. Race - A Black, W		
	Dy L	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ₹ If Yes, Give	No		1 □ Yes		Specify:			ĺ	Specify:		ite
		15. Decedent's Edi	Year or Dates:		16a Dece	dent's Usu	al Occup	ation			16b	Kind of Busine		
- Int	Completed	(Specify only highest grad	le completed)		(Give	kind of wo DO NOT u	rk done d	during most	of workin	g	100.1	Kind of Busine	:55/11100	istry
100	E	Elementary/Secondary (0-12)	College (1-4or		Farm (redit	t Adı	ninist	rati	.on	Fina	ance Ma	anag	er
A C		17. Father's Name (First, Middle, Last)				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mother	r's Name	(First, Middle				
5		Harvey Kessler	:					S	Sally	Newco	mer			
ľ		19a. Informant's Name/Relationship (7	vpe. Print)		19b. Maili	ng Address	(Street	and Numbe	r or Rura	l Route Numb	er, City	or Town, Sta	e, Zip C	Code)
		Gary Boswell -	Son		4902	Mari	ner I	rive,	Sha	dy Sid	e, 1	MD 207	764	
		20a. Method of Disposition 1 対 Burial 2 □ Cremation 3 □	Dament francis Chab	20b. P	lace of Dispo emetery, cre	osition (Name	me of other plac	e)	Da	ate	20c. l	Location - City	or Tow	n, State
		4 Donation 5 Dother (Specify			rt Lin	coln			4/4	/08	$Br\epsilon$	entwood	, M	D
		21. Signature of Funeral Service Licens	ee	L	1 2	2. Name ar	nd Addres	ss of Facility	4739	Balti	mor	e Avenu	ıe	
	1	A Consta	ree 1.	Juse						, P.A.		Hyattsv	111	e,MD 2078
١		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each l	_{ne.} stive	heart			ig, such as i	cardiac o	r respiratory a	rrest,			Approximate nterval Between Onset and Death
			Due to (or as			++0-								
à	<u>.</u>	Sequentially list conditions, i.e., and i.e. and	b. Circuit (5r en		brilla Jenoe off:	LIOII							-	
Examine		cause. Enter Underlying Cause (Disease or injury that initiated events	Diast	olic	dysfur	ction	1							
Ä	Ĭ	resulting in death) Last	Due to (or as	a consequ	uence of):									
dira	2		d					**					\perp	
Mad	Med	IF FEMALE:									-п			
Physician/Ma	9	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Feta	death 3	Ectopic p		у				23d. Date of Month		y Day Year
Vois.	386	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of d	eath 5	Other (sp	pecify)							,
		Part II. Other significant conditions co	ntributing to death I	out not resu	ulting in the u	nderlyina a	ause give	en in Part I		23e. Did t	obacco	use contribut	e to the	cause of death?
P A	3	-	3			, ,	3.11	21		11		_		bly 4∏ Unknown
Completed								-		-				
m n		·								24a. Was autoj perfo		24b. Were prior deat	to com	sy findings available pletion of cause of
		25. Was case referred to medical								1 □ Yes	2 🔁 N			⊠ No
. B	٥	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	iont a 🗆	ED/Outpotic	ot 2 17 17	Othe			(Check only o		0 TC::		
l b−	- 1	27. Manner of Death	28a. Date of Inj	ury	ER/Outpatie 28b. Time o		28c. Injun	y at		ne 5 ☐ Resi 8d. Describe		6 ☐ Other (5	ipecity)	
Certification:		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay, Year)	Injury	м	Work	(? Yes 2□N			,	,		
ific	3	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At ho	me, farm, str	eet, factory	, office		2				Rural I	Route Number,
Part		4 Homicide determined	building, e	tc. (Specif	V)					City or To	wn, Stai	te)		
edical (alcal	29a. Certifier 1⊠ Certifying Phy cone) 1⊠ Certifying Phy 2 Medical Exam	sician: To the best ner: On the basis and manner s	of examina	wledge, deat tion and/or ir	h occurred vestigation	at the tin , in my o	ne, date and pinion, deat	d place, a	and due to the	cause(date ar	(s) and manne nd place, and	r as sta due to t	ited. he cause(s)
Σ		29b. Signature and title of pertifier				290	c. License	e number			29d. D	ate signed (M	onth, Da	ay, Year)
		Com	•			F	3C614	9543			3	3/31/08	3	
		30. Name and address of person who c	ompleted cause of	death (Item	23a) (Type,	Print)								
11	-	Raj Chawla, 14300	Gallant	Fox L	ane, S	uite	210,	Bowi	e, M	D 207	15			
		31. Date filed (Month, Day, Year)	 32. Regist 											

Certificate of Death

DHMH 17 Rev 1/2001

State

Registrar

Norman Allen, M.D. 1647 Benning Road, NE #201 Washington, DC 20019

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 0 3 2008

		For State Registrar 1. Decedent's Name (First, Middle, La	State of Ma		Cert	ificate of	Death	Mental H	Reg. No.		3. Ti	me of Death	
Physicia /Medica		JOHN	BERKLI	EY	B	ARNE	TTE	Month	Day	Year O		7:36 M	
Examine		4a. Facility Name (If not institution, gir				4b. City, Town, or	r Location of Dea	ith	4c.	County of De			
		Carroll Hospita 5. Social Security Number 6.		// /	trate at a vill	West	minster If Under 24 Hr	S 0 Data at	Dist	Carroll			
Funeral Director			Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last b	Yrs.	Months Days	Hours Mir		Day, Year)	(ear) 9. Birthplace (State or Foreign Country) MD			
ortant: if itam 27 is marked other than "natural", or itams 23e or 28e-f show injury or other traumatic event, the Medical Examination in indiffer at 8.	ō	10a. State 10b. County	3.3	10c. City, To			L			10d. Inside City Limits 1 ☐ Yes 2 ဩNo			
Hou	Director	MD Carroll Westminster 10e. Street and Number 10f. Zip Code							10g. Citi	zen of What (Country?		
100		234 Warfields	ourg Road				21157		US	SA.			
zarokreczni	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or ito Rican, etc.)	No-	14. Race - American Indian, Black, White, etc. Specify: White			
1 1		15. Decedent's E	15 Decedent's Education 16a Decedent's Usual Occupation 1						16b. Ki	6b. Kind of Business/Industry			
	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)					orking						
	S	12			Owner					Hilltop Electric			
	Be	17. Father's Name (First, Middle, Las	")					, ,		Maiden Sumame)			
	ို	John Barnette	Constant Control	40		4.1		na Sipe		. T O	7. 0. /-1		
		19a. Informant's Name/Relationship Suzanne Barnette		19	19b. Mailing Address (Street and Num 234 Warfieldsbu					ninster, MD 21157			
1		20a. Method of Disposition 1 Darial 2 Cremation 3 D	Removal from State	20b. Place cemet	of Disposi ery, crema	tion (Name of story or other plac	(e) 04,	/0 <mark>7</mark> 17200	8 ^{20c. Lo}	cation - City o	or Town, Sta	ate	
		'4 □Donation 5 □Other (Specify) Carroll Cremation, Inc							Hampstead, MD				
i contra		21. Signature of Funeral Service Lice	nsee							hapel, P.A. minster, MD 21157			
once.	-	23a. Part1. Enter the disease, or con shock, or heart failure. List only	- linealine a Abrah an	the death De						ister,	_	ximate	
rial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.											
	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year			
	6	Part II. Other significant conditions	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact								co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
	Completed								utopsy erformed?	24b. Were a prior to death?	o completio	dings available n of cause of	
- 1	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of De						
	2	1 Yes 2 XNo	To inpatient 2 Ervoupatient 3 DOA 4 Nursing Home 5 Hesiden							ce 6 Other (Specify)			
	tion	1 Natural 5 Pending 2 Accident investigation	Natural 5 Pending (Month, Day Year) Injury					200. 200011	is now injury occurred				
	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (5						n (Street an Town, State	reet and Number or Rural Route Number, o, State)				
	edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)											
	We	29b. Signature and title of certifier	S HD			29c. License	389	12	29d. Dat	e signed (Mo	nth, Day, Y	ear) 08	
		30. Name and address of person who	completed cause of de		(Type, Pi	29 S	STON	ERA	NE	WEST	MINI	TER MI	
Stat		31. Date filed (Month, Day, Year)	32. Registra									157	
gistra -	r	APR 0 8	2008	ELLE A	K /	berte							
Rev 1/200	01			24/24/2	7								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 7:57 P_M **Physician** Frances Claudia Bell 12, April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner 20654 Pt. Lookout Road Great Mills St. Mary's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min. 1 M 2 F 72 217-34-2101 Director November 2, 1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Maryland St. Mary's Callaway 1 TYes 2KINo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45295 Freedom Lane 20620 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) U.S. Postal Service College (1-4or 5+) Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Turner Gabriel Dyer Ruth Ann Ridgell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Dean / Daughter 18453 Windmill Point Rd. Drayden, MD 20630 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April 18. Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part1 Enter fire is ease, roo, plications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a **Examiner** Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for a burial-tran Due to (or as the attending physician hed for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 PNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)Son's Home 1 ☐ Yes 2 ₹ No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 A Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D06419 30. Name and add est of person who completed caus death (Item 23a) (Type, Print) James P/. 24035 Three Notch Road Jarboe, M.D. Hollywood, MD 20636 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

Physician

/Medical

	Examin	ier	,	a admity realine (in not institution, give street and number)			45. City, Fown, or Education of Education					io. Godiny of Bodan			
	,487 -		Southern Mar						Inton		P	rinc	ce G	eorges	
Funeral			5. Social Security Number	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. la		If Under Months	1 Year Days		Min. (Mon	of Birth th, Day, Yea	ar)	9. Birth	nplace (State or Foreign untry)	
	Director		230-66-8721	, A M E I	56	Yrs.				11/:	28/19	/1951 Virginia			
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ocation							10d. Inside City Limits		
	aryla sho sd at	5				,		- 2						1 X Yes 2 □ No	
	Director	Maryland Prin	ce Georg	jes				ywine							
	ä	10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?				
	<u>ra</u>	11401 Cross Trail Road				20613					USA				
	r de g er m	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		edent Ever in U.S rces?	S. 13.	Was Decedif Yes, spec	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert		n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - American Indian, Black, White, etc.			
	or li	Y.	1 Never Married 2 Marr	If Yes, Giv	/e		1 ☐ Yes 2 X No Specify:					Specia	Specify: D31-		
	urai"	d by	3 ☐ Widowed 4 🂢 Divorced		ates:	400 Decedeatic Hand Occuration						-	BI	ack	
	ete	15. Deceden (Specify only highe	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						6b. Kind of Business/Industry						
	/ithin ne. han	Completed	Elementary/Secondary (0-12) College (1-4or 5+)									Major Plumbing			
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2	ould Mer arke	은	Unknown				Helen 19b. Mailing Address (Street and Number or Rural Route Number,					Bright			
3	2 sh and is m		19a. Informant's Name/Relations					•						,	
-	and ealth n 27 ner ti	1 2	<u>Jacqueline Br</u>	own/ Ex		1416	Gra	nt	Ave.					nia 23803	
5	of H of H or off		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □ Removal from	State 20b. PI	lace of Dispo emetery, cre	osition (Nam matory or ot	ne of ther plac	ce)	Date	20c.	Location	- City or	Town, State	
	Pages ment of ant: If Its ury or o		4 □ Donation 5 □ Other (S		Me	trup	2 (tan		4	1-3-08	A	EXA	udri	· VA	
Š	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Moree.		21. Signature of Funeral Service	Licensae		2	2. Name and	d Addre	ss of Facility	Adams	Fune	ral	Hom	e PA	
3	90 F # 9		May	5								o,Ma	aryl	e PA and 20608	
			23a. Part1. Enter, he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arms, Approximate Interval Between												
	Physician		Immediate Cause (Final disease or condition a Act of My D Contain Marketon Onset and De									Onset and Death			
	/Medical		resulting in death) Due to (or as a consequence of):												
	Examiner		a .ca a	0			-				U				
uted d ansit	ner	Jequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	od d ansit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
5	exection and and rial-tr	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):													
2	icate be executed physician and s the burial-transit	cal													
	ifficating by a by as the	edi		1											
5	leath certificate I attending physi I for use as the L	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	ncy						23d. Date of delivery Month Day Year					
)	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
	t the	hys	9 ☐ Unknown	9□Unkno	own										
	s than	by P	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							. Did tobacc	eco use contribute to the cause of death?				
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			1 D Van							1 ☐ Yes	2 No 3 Probably 4 Wonknown				
	w rec	Completed								24a	. Was an	24h	Were au	topsy findings available	
2	he la has ge 2	ᇤ									autopsy performed	?	death?	topsy findings available completion of cause of	
3			06.10								Yes 2	No	1 ☐ Yes	2 🗆 No	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has knowpletely filled in by the funeral director, page 2 s	sicia certi recto	Be	25. Was case referred to medica examiner?	Hospital:		<u></u>		Δ Oth	ar.	of Death (Check				-	
5	를 를 등	-T	1 ☑ Yes 2 ☐ No 27. Manner of Death	28a. Date	·	ER/Outpatier 28b. Time o		^	4 🗆 Nurs	sing Home 5	Residence cribe how in			cify)	
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	ding After fune	ion	1 Natural 5 Pendin	ig (Mont	th, Day Year)	Injury	м	8c. Injur Wor	k? Yes 2 ⊟ No		Cribe now in	ijary occu	iii eu		
	ttend death stor: the	icat	3 Suicide 6 □ Could	not be	of injury - At hor	me form et			103 2 114		tion (Ctract	and Alum	har as D	um I Pouto Number	
	or A ifter of Direction by	Certification:	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							or Town, St	et and Number or Rural Route Number, State)				
1	pital urs a eral l		CO. Cariffic III Designation To the heart make the state of the state												
	Hos 24 ho Fun Fun	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
	thin 2 thin 2 the mple	Med	one) and manner stated. 29b. Signature and title of certifier DBAFFMI DPESAWM M99 License number 29d.							294 [. Date signed (Month, Day, Year)				
	J. W. D. O.	_	1/3/1/-							7 - 1 0 - 0 C					
			With	ummu	N			<u>リ</u> γ	0604	0		0	0-	08	
(30. Name and addresslot person	who completed caus	e of death (Item	23a) (Type,	Print)		Dal	01-1	10	1-0	W.A	70	
	D		UDU+emi Op	3 Sanm	1504	5 50	rrat	15	KCI.	Clint	CD, I	TCI	_ oll	2130	
	Sta		31. Date filed (Month, Day, Year) APR 0		gistrar's Signat	H A	back	F							
	Registr	ar	HER U	0 5000	Checken 7	19									

/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural",

al Hygiene. other than "

is marked of

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item Z7 is marked any Injury or other traumatic evone.

Director

Funeral

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Completed

Be

2

Examine

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician The law requires that the death certificate be executed

burial-tra attending | the detached be completely filled in by the funeral After after death

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

within 24 hours a

To the Funeral I

edical		l								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year							
Y P		ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
q pe	RECEDIT STEDINGS	L AND SUBPLEACHNOOD HEMORE	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown							
Complete	CHRONIC LYMPI	24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No								
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
2	1 ☐ Yes 215 No		ome 5 ☐ Residence 6 ☐ Other (Specify)							
ation:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury By State of Injury at Work? M I □ Yes 2 □ No	28d. Describe how injury occurred							
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical C	29a. Certifier 1 Certifying Physical (Check on 2) Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)							
Me	29b. Signature and the of certifier	29c. License number (1) (5) (5) (8) (2)	29d. Date signed (Month, Day, Year) 16 APRIL 10, 2008							

Registrar

State

30. Name and address of person who comp

31. Date filed (Month, Day, Year)

even

APR 23

2008

DHMH 17 Rev 1/2001

900 Seton Dive, Charberland MO 21502

eted cause of death (Item 23a) (Type, Print)

mith mo

3 Registrar's Signature

			1 - For State Registrar			nd / Depa		Health and	i Mental Hy		0 0 8	132	18
ı	Physici	an	Decedent's Name (First, Middle)	Last)		~ 1			2. Date of Dea		o Xear	3. Time of D	
	/Media		Bennie			Crouch			March	27	2008°	10:12	ам
	Examir	er	4a. Facility Name (If not institution, Independence Co			110		n, or Location of De	ath		County of Death		
	Funeral			6. Sex	7. Age (In yrs.		If Under 1 Ye		rs. 8. Date of Birt		ince Ge	place (State or intry)	Foreign
	Director		197-05-9112 Usual Residence of Decedent	1⊠M 2□F	93	Yrs.	Months Day	rs Hours Mi	Septemb	er 1	7 Sou	th Caro	lina
	Marylan a-f show	tor	DC 10a. State 10b. County		10c. Cit	ty, Town or Lo Washir	eation ngton, I	OC				10d. Inside City 1∑Yes 2	
	h with the	ai Dire	10e. Street and Number 317 Bryant St.	NE	<u> </u>		10f. Zip Code	20002		10g. Citiz	en of What Cou US		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, "hy Medical Exam and must be invitited at Once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed F	2 □ No ive		Was Decedent of Yes, specify C		(Specify Yes or No- erto Rican, etc.)		4. Race - Amer Black, White Specify: B1	, etc.	
Maryland 21215-0036	vithin 72 houne. ne. .hen "nature e Medical E	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 5th	grade completed,	1-4or 5+)	(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during most of wired)	vorking		d of Business/li	Govern	ment
land 2	uld be filed v Aental Hygie rkad other t tic event, th	To Be Co	17. Father's Name (First, Middle, L Henry Crouch	ast)		Брес	.141 101		lame (First, Middle,			GOVETII	
Mary	nd 2 shouth and N 27 is ma		19a. Informant's Name/Relationsh Benita Bouknigh		ter				Rural Route Numbe			_	
altimore,	ages 1 a ent of Hes nt: if item y or othe		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State	Place of Dispo	sition (Name of natory or other p	lace)	Date 02/2008	20c. Loc	ation - City or T	own, State	1
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service L			22	. Name and Add	fress of Facility	Johnson & NW. Washi	Jenl	kins Fu		
	Physician `		23a. Part1. Enter the disease, on shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on	each line.	h. Do not ent	er the mode of d	ying, such as cardi	ac or respiratory ar			Approximate Interval Betwee Onset and De	en eath
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	-1(10)C	+ ARM					
	cuted br ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to	(or as a conseq	dialitica viy.		7, 9					
8760,	icate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to	(or as a conseq	uence of):							
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregna pirth 2 □ Feta nant at time of d lown	death 3	Ectopic pregnar Other (specify)	ncy		23	d. Date of deliv	rery Day Ye	ar
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the ur	iderlying cause	given in Part I.		bacco us		the cause of dea	
r		Completed							24a. Was a autops perfor	sy med?		opsy findings avo	
Vital	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Herrital					eath (Check only or				
0	Phys this al di	. To	1 ☐ Yes 2X No 27. Manner of Death		Inpatient 2	-	3 □ DOA	ther: 4 XNursing	Home 5 Reside			fy)	
	fte fte	tion	1 Matural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury		juryat fork? □Yes 2□No	28d. Describe h	ow injury	occurred		
Division	al or Attending s after death. Il Director: After ed in by the fune	Certification;	2 Accident investigation of Could not determine investigation investigat	ot be 28e. Place	of Injury - At ho ing, etc. (Specif	ome, farm, stre			28f. Location (Si City or Town	treet and n, State)	Number or Run	al Route Numbe	ır,
	To the Hospital within 24 hours a To the Funeral c completely filled	edicai	29a. Certifier 1 Certifying 2 Medical E	kaminier: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the c curred at the time, d	ause(s) a late and p	nd manner as s lace, and due t	stated. o the cause(s)	- 334
	vithi To ti	Σ	29b. Signature and title of certifier Phys Lh	nre	e la	ahs		nse number		The state of the s	signed (Month,		
. (5)		30. Name and ad ress of person w Dr. Mussenden	no completed cause Philip				E. Washin	gton, DC	200	02		2777.11.
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 3 2008	Barre 32. F	legistrar's Signa	ture							

			1 - For State Registrar	State	of Marylar	nd / Depa	artment of rtificate of	Health a Death	and M		iene (18	132	19
	Dharaini		Decedent's Name (First, Midd	le, Last)	,					2. Date of Deat Month		Year	3. Time of	Death
	Physici /Medi		Curtis		Cosby						31 20		7:55	р ^м
	Examir		4a. Facility Name (If not institution	•	umber)		4b. City, Town,	or Location of	of Death		4c. County			
			Gilchrist	Center	T =		Towso		5. U 1		Balt			
	Funeral Director		5. Social Security Number 579–16–7434	6. Sex 1 🔯 M 2 🗆 F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day,			place (State of ntry) nnsylv	
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	cation						10d. Inside Cit	ty Limits
	Mary f ehc	ក្ត	Md.		Ва	altimo	ore						1X Yes	2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of \	Vhat Cou	ntry?	
	h witl		6108 York	Rd.			21212	2			U.S.A	<i>A</i> .		
	deal	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Orig	gin? (Spe	ecify Yes or No-		e - Ameri	can Indian,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	b	1 ☐ Never Married 2 ☐ Mai 3 🖫 Widowed 4 ☐ Divorced	ried 1 ⊠ Yes	2 No. 1943 ive 1945 Dates: 1945	_	1 ☐ Yes 2 🙀 No		i, r doito	riodii, oto.)	Specify		ack.	
2-0	72 ho	Completed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occu		t of worki	na	16b. Kind of B	ısiness/In	idustry	
2	ithin Man	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	ed)	OI WOIKII	rig				
2	ygier her th		12			Pri	nter	1			Gove		ent	
Maryland 21215-0036	id be fi ental H ked oti ic ever	To Be	17. Father's Name (First, Middle, Thornton Co	osby					rs Name atie	(First, Middle, M		10)		
ary	shou and M mar umat	-	19a. Informant's Name/Relation:	ship (Type, Print)	aughte	19b. Mailir	ng Address (Stree	t and Numbe	r or Rura	I Route Number	City or Town,	State, Zip	Code)	
	and 2		Sonja C. Eg	blomasse	-	6108	York F	Rd., E	Balt	imore,	Md. 2	2121	2	
ore	of He of He fiten		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 Pomoval from		Place of Disponentery, crer	sition (Name of natory or other pla	ace)			20c. Location -			
Ĕ	Pag ment ant: i		4 Donation 5 Other (S		Fo	rt Li	ncol Ce	em.	4/7/	'08 E	rentwo	ood,	Md.	
Baltimore,	permit. Depart Import any in		21. Signature of Funeral Service	Urlan			Name and Addr							0011
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the deat								Approximate Interval Betv	
	Physician		Immediate Cause (Final disease or condition) _	II t	3 -0.144.18	n Fo	acti	110				Onset and D	Death
	/Medical		resulting in death)	a. Due to	(or as a conseq	uence of):	7) 1 4 6	٠٠١٠	~ Q					
	Examiner		Sequentially list conditions	b										
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	premier of).								
	sate be executed physicien and the burial-transit	каш	that initiated events resulting in death) Last	C. Due to	(or as a conseq	ucasa st).								
8760,	be ex icien burial	a E	3 ,	D09 (C	(or as a conseq	uence or):								
87	physics the	dic		d.										
9 X	certifi Iding	Physician/Medical	IF FEMALE:	23c. If yes, or	itcome of pregna	ancv					22d Day	بالمام المام		
Вох	atter I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of d	il death 3□	Ectopic pregnand Other (specify)	Э			Mo	e of deliventh	•	rear
P. O.	the d	lsk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unki			Journal (Specify)		-					
τ <u>,</u>	wrequires that the death certific been signed by the attending p should be detached for use as	by PI	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause g	ven in Part I.		23e. Did tob	acco use cont	ibute to t	he cause of d	eath?
rds	quire on sig uld ba	De De	aspirat	ug pro	neum	our	1			1 □ Ye	s 2 No	3 🗆 Prot	bably 4 XU	Inknown
ပ္ပ	law re as bee 2 sho	olet	Proetal	o Colv	COD					24a. Was ar	n 24b. \	Vere auto	opsy findings a	available
Division of Vital Records,	The lay	Completed		C CCC						autops	ed?	prior to co death?	mpletion of ca	ause of
ita	ien: rtifica stor. p	Bec	25. Was case referred to medica	Ι [26. Place	of Death	(Check only one			200,110	
<u>~</u>	hysic nis ce I dire	Jo.	extrminer? 1 ☑ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA	hor		ne 5 🗆 Reside	N. C	er (Specif	y) Hos	DICCO
C	ng P	5	27. Manner of Death 1 □ Natural 5 □ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju	iry at ork?	2	28d. Describe ho	w injury occurr	ed	1	
sio	tendi leath. lor: A the t	cat	2 Accident investi	gation Februar	Y 29,2008			Yes 2		+	-all			
<u>></u>	i or Attendater deatl	Certification;	4 Homicide determ	nined 289. Plac	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, str	et, factory, office		2	28f. Location (Sti City or Town	reet and Numb , State) 6	or Rura	al Route Numi	ber,
_	pital ours a erai I		29a. Certifier 1 ☐ Certifyii	o Physician: To th	a bast of my leas	uuladaa daash			4-1	Baltin	M, sron	02	1212	5
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical one)	ng Physician: To th Examiner: On the l and mar	pasis of examina nner stated.	ition and/or inv	restigation, in my	opinion, deat	th occurre	and due to the ca	iuse(s) amd ma ite and place, i	nner as s and due to	stated. o the cause(s))
	To the To the Comp	ž	29b. Signature and title of certifie		i		29c. Licen	se number		25	9d. Date signed	(Month,	Day, Year)	
1			think find	MD !	Eput.	7	DIS	366	7	1	Iraf	1 3	2005	~
18	7)		30. Name and address of person	who completed cau	se of teath (Item	a 3a) (Type,	Print)			()	1	- 1		J
7			Philip Mi	1:4616	MD		mble	11:11	JT.L	u then	ille,	Mq	210	63
4.	Sta Registra		ΔPR 0 3 2008	See 32.1	legistrar's Signa	Plum					•			-

P.O. Box 68760 658070 Records, Physician:

Division or Vital

the Hospital or Attending hin 24 hours after death. the Funeral Director: A filled in by Medical ပ္ Registrar

Physician/Medical 2 Completed Be ၉ Certification:

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifited at

Physician

/Medical

Examiner

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certificate has

this funeral

After t

physician

Maryland 21215-0036

Baltimore,

29b. Signature and title of certifier State

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLANGUSBURG, MD _207/0.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 Homicide

(Check only one)

6 Could not be determined

3 2008

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMonth . Year **Physician** 10:42 AM 2008 Walter E. Chaney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washinton County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Days Hours Min. Director 84 Feb. 13,1924 Maryland <u>219-10-4788</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 213 Winding Oak Drive 21740 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Operations Manager Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John E. Chaney Rena Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traconce. 213 Winding Oak Drive, Hagerstown, Maryland 21740 Catherine P. Chaney/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 4/10/2008 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, 21. Signature of uneral Sen P. A. Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ridner Immediate Cause (Final einenna Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an was a... autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the dead of the cause of the dead of the cause of the cau 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

HABIB

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251

32. Registra

2008▶

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E ANTIETAM ST, HAGERSTOWN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician DEVORE** WILLARD 10:53P MARCH 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 8. Date of Birth DEC. 15, 1954 if Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days NEW YORK 1 🖾 M 2 🗆 F 063-46-6765 53 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director D.C. WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20003 33 K St., N.W. #807 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 BLACK þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE N. DEVORE CARRIE BELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) is 1 and 2 soft Health ar 23 ANACOSTIA RD. N.E. WASH., D.C. 20019 PATRICIA D. PAIGE/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ott
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ② Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 4/3/08 BELTSVILLE, MD. CAPITOL MORTUARY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1425 MARYLAND AVE., N.E. WASH., D.C. 20002 23a. Part 1. Enter the dise se, or complications that coulsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. Ust only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Myscarshal **Physician** Acut /Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the aftending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lu actidos 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760 or Attending Physician:

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29b. Signature and title of certifier

(Check only

29c. License number

P47446

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 3.31.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Avesuit 3-41 silva spring MD 20902 ROINTAN FARAHIF AR

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008



			For 1 - State Registrar	State of Ma	•	epartme Certifica			Mental Hy	/giene Reg. No		10220
			Decedent's Name (First, Middle, Last)						2. Date of De	eath		3. Time of Death
	Physicia /Medic		Tames A.	Darb	4. Jr	-			Month O4	ح ا	Vear OS	12:50 PM
1	Examin		4a. Facility Name (If not institution, give s	treet and number)))	4b. City	, Town, or	Location of Death			. County of Death	
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Maryland 21215-0036	2 sho and is m		19a. Informant's Name/Relationship (Typ			3		nd Number or Ru				ip Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinat must be multiped at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery,	crematory or	other place	9)	54.0	200. L	ocation - Oity or i	OWII, State
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Physician /Medical Examiner ē

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

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Baltimore,

Division or Vital Records, P.O. Box 68760

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27. Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide

4 Homicide

(Check only

29a. Certifier

28a. Date of Injury (Month, Day Year)

6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05 e 00

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 09 2008 egistrar's Signature

Injury

118

within Somple

08-02463 Calvin C. Ford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not institution, give street and number)		41	o. City, Town, or			1011 20, 2	4c. Cou	unty of Death	1
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F % F 3	Me	29b. Signature and title of certifier	7			se number				e signed <i>(Me</i>	onth, Day, Year)
		30. Name and address of person who completed cause of d		23a)	0.0	·, (VI. L.)			IVIGICII	20, 2000	
		Tasha Greenberg MD. Assistant Medica			Penn Street	, Baltimor	e, MD 21	201			
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			For State Registrar		State of M	aryland /	-			lealth and Death	l Mental F	lygier Reg. M		13220
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	/Medic Examir		4a. Facility Name (I	If not institution, gi	ve street and number,)		4b. City	, Town, or	Location of De			4c. County of Dea	
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	Funeral		5. Social Security N	lumber 6.	Sex 7. Ag	ge (In yrs. last	birthday)	If Unde	r 1 Year	If Under 24 H		Birth	9. Bir	thplace (State or Foreign
	Director		381-10-8	781	1 □ M 21€ F	88	Yrs.	Months	Days	Hours Mi	Aug.	Day, Yea 2, 1		ichigan
	D		Usual Residence of	f Decedent										
	rylar	_	10a. State	10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits
	Ma-f-s	cto	Md.	Montg	omery	Si	lver	Spri	ing					1 X Yes 2 No
	or 28	lire	10e. Street and Nu	mber				10f. Zi	p Code			10g. 0	Citizen of What Co	ountry?
	15 wi	Funeral Director	210 E.Ir	ndian Spr	ing Drive			2	20901			U	.S.A.	
	dea ma	ner	11. Marital Status		12. Was Decedent Armed Forces		13. V	Vas Dece	dent of H	ispanic Origin? In, Mexican, Pui	(Specify Yes or	No-	14. Race - Ame Black, Whit	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene liem 27 is marked other than "natural", or itema 23 or 28a-1 show other traumatic event, the Medical Eventinal must be routiled at	by	1 ☐ Never Marr 3 🛣 Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			☐ Yes		Specify:	0110 1110211, 010.,		Specify: Wh	
2-0	72 hc	tec	(Sner	15. Decedent's E	ducation	16	Sa. Deced	ent's Usu	al Occup	ation	ndina.	16b.	Kind of Business	/Industry
21215-0036	within and the state of the sta	Completed	Elementary/Seco		College (1-4or	5+)		eric		during most of w	ion in g		Retail	
d 2	filled Hygi ther		17. Father's Name	(First, Middle, Las	t)			erre	ат	18. Mother's N	ame (First, Mid	dle, Maid		
Maryland	Aental Aental rked c	To Be	Charles	William	5					Mari	on Hu	ghes		
ary	should have		19a. Informant's N	ame/Relationship	(Type, Print)	1	9b. Mailing	g Addres	s (Street	and Number or	Rural Route Nu	mber, City	y or Town, State,	Zip Code)
	and 2 valth n 27 I		Jan Ben	son/ Dau	ghter	5	ilve	r Sp	dian	Spring Maryl	Drive	901		
Sre	ot He		20a. Method of Dis		☐Removal from State	20b. Place ceme	of Dispos	sition (Na natory or	me of other place	(e) Ana	Date	20c.	Location - City or	Town, State
Ĕ	Pag nent int: I			5 Other (Speci		Metro					008	A	lexandri	a, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than any Injury or other traumatic event, It a Ms ODGs.		21. Signature of Fu	meral Service Lice	nsee		22.	Name a	nd Addres	ss of Facility	Hysong e., N.W	-	oany sh., D.C.	20007
	61		23a. Part1. Enter t	he disease, or con	nplications that cause one cause or each I	d the death. D								Approximate
)	Physician		Immediate Cause	(Final	CD + 1									Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	on (1)		a consequence	e of):							
	Examiner			- 1	2000	INSONS		DICE	195 E					
3	生 人 子部	ē	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	inditions,		a consequence		-136	117 -					
	icate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or that initiated events	injury	. Ann	RESIA								
o î	exec an an rial-tr	EX	resulting in death)	Last	Due to (or as	a consequenc	e of):							
68760,	icate be executed physicien and s the burial-transit	cai		- (_ d.									
	titica ig phi as th													
Box	eath certiti attending	2	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			F-1				Ŋ,	23d. Date of de	livery
	deati e atte	Physician/M	in the past 12 1 Tes 2	months?	1 Live birth 4 Pregnant a			Other (s	regnancy pecify)				Month	Day Year
P.0	thet the de led by the a detached	hys	9 □ Unknown		9 Unknown									
	es Ded	ру Р	Part II. Other signif	ficant conditions	contributing to death t	out not resulting	g in the un	derlying	cause give	en in Part I.			,	the cause of death?
of Vital Records,	w requir been s should	Completed									- 1	Yes	24 No 3 □ Pi	robably 4 Unknown
Ö	elaw hasb je 2 st	pie									24a. W	has an utopsy	24b. Were at	topsy findings available completion of cause of
<u> </u>	ysician: The is certificate hi director, page	ő									p	erformed s 2/21		2 □ No
/ita	ilcian: Th certificate rector, pag	Be	25. Was case refer examiner?	red to medical						26. Place of D	eath (Check or	ly one)		
7	hysic his ca I dire	2	1 ☐ Yes 2 Ø		Hospital: 1 Inpati	ent 2 ER/	Outpatient	3 D	OA Oth	er: 4 🛮 Nursing	Home 5□ R	esidence	6 □Other (Spe	city)
0 4	ding Ph h. Atter th funeral		27. Manner of Deat	h 5 🗌 Pending	28a. Date of Inju (Month, Da	ury 28b	Time of Injury		28c. Injun Worl	/ at k?	28d. Descri	be how in	jury occurred	
000	ottendin death. ctor: Atl	ati	2 Accident	investigation				М		Yes 2□No				
Division	or Attencatter death	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of in	jury - At home, tc. <i>(Specity)</i>	farm, stre	et, factor	ry, office		28f. Location City or	n (Street Town, St	and Number or R ate)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely tilled in by the funeral director.	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	ige, death and/or inv	occurred	at the tin	ne, date and pla pinion, death oc	ce, and due to	he cause ne, date a	(s) and manner as	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and	I title of certifier	and manner si			29	c. License	e number		29d. f	Date signed (Mont	h, Day, Year)
	8 ≒ ۶ ⊣			Markle &	why -				_	051158			APRIL 1	2008
/	62					d	- \ CT	D-i-41	100	15/158		1	71111	2008
	(3)		4	_	completed cause of		a) (Type, F		72	CKVILL	15	HO	20850	
	Sta	to	31. Date filed (Mon	of to avy	32. Regist	rar's Signature	->1011	V L	100	CKYILL	-		-4030	
	Registr		APR 0	3 2008	Green	rar's Signature	we	•						

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Stat Registra

	Please 1	Type or Print in I				•	•	
	For State Registrar	State of Marylar		tificate of De			ene g.No? () () {	3 3227
	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
n il	Faye Winifred For	ct				April 1	Day Yea 2, 2008	4:32 p.m
" r	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	npili 1	4c. County of De	
	37845 Paul Ellis H	Road		Avenue			St. Mary	.† _C
ï	5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year If		8. Date of Birth	9 F	irthplace (State or Foreign
	577-58-2242	□M 2X1F 6	2 Yrs.	Months Days F	lours Min.	(Month, Day, 05/29/19	945 Oh:	Country)
	Usual Residence of Decedent					03/ - 0/ 10	143	
	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
completed by Funeral Director	Maryland St. Mary	's Ave	nua					1 ☐ Yes 2 🛣 No
ě	10e. Street and Number	J AVE	me	10f. Zip Code		10	g. Citizen of What	Country?
<u> </u>	22749 St. Winifred	lla Tama		20609		TT.	nd to J Ct -	. .
2	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. V		nic Origin? (Spec		nited Sta	nerican Indian.
5	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 💆 No	li li	Vas Decedent of Hispa f Yes, specify Cuban, I	Mexican, Puerto F	Rican, etc.)	Black, WI	
2	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2XNo S	pecify:		Specify:	Vhite
מכ	15. Decedent's Edu	cation	16a, Deced	ent's Usual Occupatio	n	1	6b. Kind of Busines	
1	(Specify only highest grad	e completed)	(Give I	kind of work done duri OO NOT use retired)	ng most of workin	g i	ob. Killo of busines	S/Modelly
Ė	Elementary/Secondary (0-12)	College (1-4or 5+)	Manage				Dotail	
	17. Father's Name (First, Middle, Last)		Tranage		Mothor's Name	(First, Middle, M.	Retail	
מ		_		10	. Mother's Marile	(First, Mildale, Mi	aideri Surriame)	
2	Don Franklin Esloc				inifred_			
	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailin	g Address (Street and	Number or Rural	Route Number,	City or Town, State	, Zip Code)
	Rochelle Hogan/Dau		37845	Paul Elli:	s Road,	Avenue.	MD 2060	9
	20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ F		Place of Dispos	sition (Name of natory or other place)			0c. Location - City	or Town, State
	4 Donation 5 Other (Specify)		inefial	d-Echols C	0/./15	/2000 0	hamlatta	II. 11 MD
	21. Signature of Funeral Service Licens	ee /	22.	Name and Address o	f Facility	-61-11-7	nariotte	narr, MD
	Kyle S. Simons	M01206	2	2055 11-11	Brin	silerq F	uneral H	ome, P.A.
	23a. Part1. Enter the disease, or compl			2955 Holly				Approximate
cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): uence of):	ancer				
בַּ								
r i yaiciai i/imedica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown	Sc. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause given ir	Part I.	23e. Did toba	acco use contribute	to the cause of death?
fa posidino	COPD					1 XYes	2 No 3	Probably 4 ☐Unknown
2						24a. Was an autopsy	24b. Were prior to	autopsy findings available completion of cause of
						perform 1 Yes 2	ed? death' QNo 1 □ Ye	?
	25. Was case referred to medical examiner?			26	. Place of Death	(Check only one))	
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Other:	4 ☐ Nursing Hom	ne 5□Residen	ce 6 XOther (St	Daughter's Decify) Home
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	20	8d. Describe how	injury occurred	,,
	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORTH, Day Tear)	IIIJui y		2 🗆 No			
	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office	20	Bf. Location (Stre City or Town,	eet and Number or s State)	Rural Route Number,
	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	occurred at the time, o	date and place, a	nd due to the cau	use(s) and manner te and place, and d	as stated. ue to the cause(s)
1	29b. Signature and title of certifier	and mainter stateu.		29c. License nu	mber	20.	d. Date signed (Mo.	oth Day Year
	and the distance	2001			557	51	4-15	
-	80	1000	<u> </u>				7-13	-00
	30. Name and address of person who co			•				
	Jennifer Schmidt,		Merchan	its Lane, I	eonardto	own, Mar	yland 20)650
	31. Date filed (Month, Day, Year)	32. Registrar's Signa	nure					
.3	APR 1 6 200	10 Bleeve D	- Apa	W .				
1								

08-02687 Bruce David Gill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 13228

ice David Gill		1- For State Certificate of Department of The		Reg. I	∠. U :\ No	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da	ay Year	3. Time of Death 1513 hrs
dical Examir			City, Town, or Location of De	April 5, 2008	4c. County of Death	L
		4a. I dollar frame (il fiet illette della gire este elle	cockeysville		Baltimore Cou	
Funeral Director		5. Social Security Number	Months Days Hours	Hrs. 8. Date of Birth(1 Min. 11/08/1	948 Foreign	thplace (State or Maryland
»	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d 10w any		Maryland Carroll Hampstead				1 Yes 2 X No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 4420 Black Rock Road, Unit 3	Of, Zip Code 21074		Citizen of What Cou	
with th			ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
fler death ", or iten	y Funeral	3 Widowed 4 Divorced in test Give test 1 909-1970 1 10	es 2 X No specify:		Specify: wh	ite
nours a natura Examin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Leducation (Specify only highest grade completed) 17b. Decedent's Education (Specify only highest grade completed)	Usual Occupation (Give kind of working life. DO NOT use		6b. Kind of Business state vet	· ·
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) grounds	-		cemetery	
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleat and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Con	Chester Vernon Gill	Barba	Name (First, Middle, Ma Para Louise	Stonesife	
21; should be and Men	₽	19a Informant's Name/Relationship (Type, Print) 19b, Mailing Ad	ddress (Street and Number lack Rock Rock	er or Rural Route Numbered, Unit 3	er, City or Town, Stat Hampstea	d, MD 21074
and 2 sho fealth and item 27 is		20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery,	Date	20c. Location - City of	or Town, State
nore Pages 1 ent of 1 nt: If		1 XBurial 2 Cremation 3 Removal from State crematory or other Garrison Fo		April 11, 2008	Owings Mi	lls,Maryland
Baltimore, permit. Pages 1 an Department of Hee Important: If itel		21. Signature of Funeral Service Censee 22. Nam	ne and Address of Facility South Main S	Eline Fune	eral Home	D 21074
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the r				Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiov				Death
ammer		or condition resulting in death) Due to (or as a consequence of):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				1
e executed sian and ial - transit	Medical					
760, ficate be g physic the buri			death 3 Ectopic p	pregnancy	23d. Date of deliv Month	ery Day Year
Box 68760, death certificate be except at attending physician ed for use as the burial.	Physician/	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)			
). Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part			to the cause of death?
P.O. res that t	d b	Diabetes mellitus, chronic alcoholism		1Yes		robably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requir is after death. Director: After this certificate has been is led in by the bineral director, page 2 should I	Completed			24a. Was a autops	y prior	autopsy findings available to completion of cause of ?
Reco	l mog		00 Plus (D. all. (C	1 ✓ Yes 2		
ital Rec sician: The sicertificate irector, page	a	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient	26.Place of Death (C		Residence 6 🗸 Ot	her: Scene
of Vi ling Physi After this funeral dii	유	27 Manner of Death 28a, Date of Injury 28b, Time of Injury		l l	ow injury occurred	
Sion Attendi death. ctor: /	atio	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street,	1 Yes 2 1		treet and Number or	Rural Route Number, City
Divisior pital or Attend ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	, ractory, onice boliding, etc	or Town, St		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Co		ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)
	ĕ	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
WIL		Jante Heg mis	O.C.M.E.		April 6, 2008	
STIVA		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 P	Penn Street, Baltimor	re, MD 21201		
Regi	itate	1 D D D D D D D D D D D D D D D D D D D	N. s			
DHMH 17 Rev 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 8:20 p.m. Thomas Glenn Gilbert April 10, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Leonardtown Leonardtown If Under 24 Hrs. St. Mary's Nursing Center St. Mary's Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1X M 2□ F 49 10/12/1958 213-70-5216 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21585 Peabody Street 20650 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 🖾 Divorced White 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judith Lynn Brown Thomas W. Gilbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Waybright/Uncle 1023 Wiltshire Drive, LaPlata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Manor Church Cemetery 04/15/2008 Boonesboro, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Department of Health ar important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

la or 28a-f show t be notified at

ns 23a must b

the

Directo

Funeral

þ

Completed

Be 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examine burial-trar physician Be Certification: To

Physician/Medical þ Completed

Hospital or Attending Physician: The law requires that the death certificate be executed After t within 24 hours after death. To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

To the

Medical

State

24a. Was an

performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

autopsy

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

and manner stated. 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

Injury

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

James P. Jatboe, 24035 Three Notch Road, Hollywood, MD M.D

31. Date filed (Month, Day, Year) 1

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes

27. Manner of Death

1 🖪 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** a ^M 28, 2008 4:54 MARCH HOWARD DAVID Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES CIVISTA HOSPITAL <u>LaPLATA</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 6. Sex **Funeral** Days Min. Months Hours 1 € M 2 🗆 F 3, 1953 Wash., Director 55 579-72-4437 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or itams 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1ĂYes 2□No Funeral Director Waldorf Md. Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20641 2164 Pineview Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 28 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: if item 27 is marked other than "ns any injury or other traumatic event, The Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 10th Drywall Plaster Finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lemuel Howard ပို Anna Mae Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Howard / Wife Waldorf, Md. 2164 Pineview Court 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 4-4-08 Landover, Md. Harmony 22. Name and Address of Facility Capitol Mortuary, Inc. 21. Signature of Funeral Service Micenses 1425 Maryland Ave., NE Approximate Interval Between Onset and Death 23a. Paint1. Enter the disease, shock, or heart failure. Li complications that caused the death. To not enter the mode of dying, such as cardiec or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed vvere autopsy findings available prior to completion of cause of death? 24a. Was an 24b. Were autopsy findir has autopsy performed? certificate I 1 Yes 1 ☐ Yes 2 ☐ No 2 To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? After t 27. Manner of Death 28d. Describe how injury occurred Certification: 1-Natural 5 Pending after death.

Diractor: Af
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funarai (rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State

31. Date filed (Month, Day, Yeer) APR 03 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/Amend#28e.28f.PerPhys.PGC4-3-08Cr Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician AM 07:30 28 2008 March Haske Kobert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayren Medical 7. Age (1) Baltimore Hopkins Center If Under 24 Hrs Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1፟፟፟፟ M 2□F 1925 Washington, 83 Jan 16, Director 578-12-3474 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show Examiner must be notified at 1 X Yes 2 No Hyattsville Prince George's Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be monee. USA 20781 5317 42nd Avenue Funeral Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I ZYes 2 ☐ No f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 WWII Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Corp of Engineers Administration Management 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ottilia Zinc Francis Haske P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5317 42nd Avenue, Hyattsville, MD Margaret D. Haske - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Alexandria, Virginia 3/30/08 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or conglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 2 day DERTY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con a quence of) Examiner bunial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? /es 2 No 2 🗌 No 1⊟ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No PM 2:30 March 26,2008 Pants caught fire while burning 2 Accident filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Newson of Revenue Number City or Town, State) 4613 S. Politica Rd. 3 ☐ Suicide determined 4 ☐ Homicide Harwood, Md. 2007 Second Home i 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State APR 03 Registrar

32. Registrar's Signature

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

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		1 - For State Registrar	State of M	•	epartment of the control of the cont		F	leg. No.	8 13232
Physic	ian	1. Decedent's Name (First, Midd Debbie Li	_{lle, Lasi)} ynn Harbaugh				2. Date of Dea	11, Day 2008	3. Time of Death 9:40 P. M
/Med Exami		4a. Facility Name (If not institution			4b. City, Town, o	or Location of Deat		4c. County of	
		NMS Healthcar				rstown		Washir	
Funeral Director		5. Social Security Number 219-66-1669	6. Sex 7. A	ge (In yrs. last birthd 52 Yrs	Months Davs		8. Date of Birth (Month, Day March	Year) 19,1956 N	n. Birthplace (State or Foreign Country) Maryland
land		Usual Residence of Decedent 10a. State 10b. County	<i>y</i>	10c. City, Town or	r Location		10d. Inside City		
Mary a-f sh	to	WV. Ber.	keley	Hedge:	sville				1 ☐ Yes 2 ☐ No
h with the 23a or 28	al Director	10e. Street and Number 455 Beards Cr	ossing Rd.		10f. Zip Code 2	25427		10g. Citizen of Wh. $U \cdot S$	
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural; or items 23s or 28s-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma. 3 Widowed 4 Divorce	MV Circ	Ever in U.S.	I3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. <i>White</i>
5-0 72 ho	eted	15. Decede (Specify only highe	nt's Education est grade completed)	16a. De	ecedent's Usual Occupive kind of work done to DO NOT use retire	pation during most of wo	rking	16b. Kind of Busin	ness/Industry
Vithin sne.	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or	5+) lift	e. DO NOT use retire Housekeej	oing		<i>Hotel</i>	
yland 212 ould be filed withi Mental Hygiene. arked other then atic svent, trail	Be	17. Father's Name (First, Middle Carroll L.					me (First, Middle, n M. Byr	Maiden Sumame) đ	
Maryla 12 should 12 should 12 should 12 should 12 should 12 should 13 should 14 should 15 should 16 should 17 should 18 should	70	19a. Informant's Name/Relation Stephanie L. Ke	ship (Type, Print)		ailing Address (Street 2 Tammany	and Number or Ru	ıral Route Numbe	r, City or Town, St	ate, Zip Code) 1. 21795
Baltimore, Maryland 21 Permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier mportant: if item 27 is marked other th my injury or other traumatic event, tall page.	1	20a. Method of Disposition 1 🗆 Burial 2 💆 Cremation	3 Removal from State	20b. Place of Di	sposition (Name of crematory or other pla	Apr.	Date il 15,	20c. Location - Ci	ty or Town, State
Baltimo permit. Page Department of important: if eny injury or		' 4 □Donation 5 □ Other (: 21. Signature of Funeral Service			urg Cremat 22. Name and Addre	and of Capilla	08	505 - 7	
De gen in gen		Joly /	e Davis	M01414	J.L. Davis	Funeral	Home _{Smi}	thsburg,	vd. 21783
Physician /Medical Examiner		22 Puril. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Finat disease or condition resulting in death)	t only one cause on each	d the death. Do not line. Calculation of the consequence of the conse	enter the mode of dy	_	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
		Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Usa to (or as	s a nonsaquanca of):					
68760, ficate be executed physician and ts the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	s a consequence of):					
BOX 6 ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 This 9 Unknown		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy .		23d. Date of Month	
'dS, P.O. I	þ	Part II. Other significant condit	ions contributing to death	but not resulting in th	e underlying cause gr	ven in Part I.			ute to the cause of death? Probably 4 Sunknown
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To the Hospital within 24 hours a To the Funaral (edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the besi I Examiner: On the basis and manner s	of examination and/o	eath occurred at the to or investigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifi	er		29c. Licen	se number		29d. Date signed (
		30. Name and address of person	n who completed cause of	death (Item 23a) (Ty		2323		4-15-	2008
		Khalid Waseem	· · · · · · · · · · · · · · · · · · ·			Md. 21742			
St Regis	ate	31. Date filed (Month, Day, Year	32. Regist	trar's Signature	Sugar H .				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 08-02677 Matthew William Hamby Certificate of Death 1- For State Registrar Reg. No. 2. Date of Death 3. Time of Death

To a. State 10b. County 10c. City. Town or Location 10c. Cit	place (State or Foreign try)
Funeral Director Funeral Director Social Security Number 6. Sex 7. Age (In yrs. last birthday) 218-54-9989 1	olace (State or Foreign try) ington D.C.
S. Social Security Number 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 218-54-9989 1 X M 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 207-35 USA Martial Status Martial Status Martial Status Martial Place Martial Place 207-35 Martial Status Martial Status Martial Place Martial Place 1 X N 2 F 58 Yrs. Months Days Hours Min. Dec. 15, 1949 Wash 207-35 USA Months Days Hours Min. Dec. 15, 1949 Wash 207-35 USA Martial Status Martial Status Martial Place Martial Place 1 X N 2 F 58 Yrs. Months Days Hours Min. 207-35 USA Martial Status Martial Status Martial Place Martial Place Martial Place 207-35 USA Martial Status Martial Status Martial Place Martial Place Martial Place 1 X N 2 F 58 Yrs. Months Days Hours Min. 207-35 USA Martial Status Martial Place Martial Place Martial Place Martial Place 207-35 Martial Status Martial Place Martial Place Martial Place Martial Place 208-21 X N 0 specify: Specify Vest or No. 1 X N 2 F 58 Yrs. Months Days Hours Min. 209-21 X N 0 specify: Specify Yes or No. 1 X N 2 F 58 Yrs. Months Days Hours Min. 209-21 X N 0 specify: Specify Yes or No. 1 X N 2 F 58 Yrs. Months Days Hours Min. 209-21 X N 0 specify: Specify Yes or No. 1 X N 2 F 68 207-35 Martial Status Martial Place Mart	ington D.C.
218-54-9989 1\text{IX} M 2 F 58	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Clinton 10f. Zip Code 20735 USA Maryland Prince Georges 10g. Citizen of What County 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- 11g. Was Decedent of Hispanic Origin? (Specify Yes or	
To a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City Town	ou, maide on y zame
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24a. Was an autopsy performed? death?	utopsy findings available completion of cause of
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Y 26. Place of Death (Check only one)	es 2 No
So was case referred to medical examiner? 1 ✓ Yes 2 No 24a. Was an autopsy performed? 1 ✓ Yes 2 No 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 26. Place of Death (Check only one) 27. Wanner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
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Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or For Town, State)	tural Route Number, City
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	ated. the cause(s)
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≥ 29b. Signature and title or certifier	
Why Diassell Mid	fonth, Day, Year)
30. Kame and address of person who completed cause of death (Item 23a) Melissa Brassell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
DO()	
State State Registrar 31. Date filed (Month, Day, Year) 8 2008 32. Registrar's Signature	

Registrar DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Division or Vital Records, P.O. Box 68760 within 24 hours a To the Funeral I

> State Registrar

DHMH 17 Rev 1/2001

APR 0 9 2008

OGE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA



EASTERN

SALISBURY, MD 21864

			1- State of Maryland / Department / Department / Dep	artment of Health and M rtificate of Death	lental Hygier Reg. N	- 7 H H H	13235
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles Henry Jones, Jr.		2. Date of Death Month 4/1/200)ay Year	3. Time of Death 6:45 ^a M
1	Examin Funeral		4a. Facility Name (If not institution, give street and number) 4311 39th Place 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 7/4 Yrs.	4b. City, Town, or Location of Death Brentwood If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Prince Ge 9. Birthp	lace (State or Foreign try)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of fhealth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show the than "natural" or Items 23a or 28a-f show the traumatic event, the "natural Exami her matter a notified at o	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Prince George's Brentwood 10e. Street and Number 4311 39th Place 11. Marital Status 1	10f. Zip Code 20722 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto II □ Yes 2 ☑ No Specify: dent's Usual Occupation kind of work done during most of working DO NOT use retired) 11 □ Yes 11 □ Yes 12 □ No Specify: 12 □ Yes 2 □ No Specify: 13 □ No No Specify: 14 □ Yes 12 □ No Specify: 15 □ No No Specify: 16 □ No Specify: 17 □ No Specify: 18 □ No Specify: 18 □ No Specify:	acify Yes or No-Rican, etc.) 16b. Was (First, Middle, Maide ne Furey al Route Number, City	U.S. 14. Race - Americ Black, White, e Specify: Wh Kind of Business/Ind	A. an Indian, etc. ite dustry
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 By Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 3 Removal from State 4 Removal from State Ammendale 22. Signature of Funeral Service Licensee 3 Removal from State 4 Removal from State Ammendale 25 Removal from State 4 Removal from State 4 Removal from State Ammendale 5 Removal from State 6 Removal from State 4 Removal from State 6 Removal from State Ammendale 6 Removal from State	sition (Name of natory or other place) Cemetery 4/5/2 Name and Address of Facility asch's Funeral Home	2008 Bel 2008 P.A. H	Location - City or To tsville, 739 Balti	
, personal	Physician /Medical Examiner burial-transit sthe prival ransit steep prival ransit stee	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		n tespiratory arrest,		Approximate Interval Between Onset and Death Wel KS
P.O. Box 68	at the death certifica I by the attending ph stached for use as th	Physician/Med	1 Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)			Day Year
ords, I	equires the en signed ould be de	þ	Part II. Other significant conditions contributing to death but not resulting in the un Prostate Camcer, Hypertension	nderlying cause given in Part I.	23e. Did tobacco	use contribute to th	
vital Records,	n: The law re ificate has be or, page 2 sho	Completed	Diabêtes Mellitus, type 2 25. Was case referred to medical			24b. Were autop prior to cor death? 1 ☐ Yes	osy findings available npletion of cause of
DIVISION OF VI	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	was dase referred to medical examiner? 1	28c. Injury at Work? M 1 □ Yes 2 □ No	me 5 Residence 28d. Describe how inj 28f. Location (Street City or Town, Ste	ury occurred and Number or Rura	
2	Hospital or 24 hours aft Funeral Di etely filled in	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatled. 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place	and due to the cause	(s) and manner as s	tated. the cause(s)
•	To the within compl	Me	29b. Signature and title of certifier	29c. License number D61007	/	Pate signed (Month, I	2008
R	V+1	d l	30. Name and address of per on who completed cause of death (Item 23a) (Type, KENNETH KHANDAGLE 831 E. UNIVELS(LY	Print) Vd #25 Silver Sp	ring, Mar	yland 2090;	3
	Sta Registr		31. Date filed (Month, Day, Year) APR 9 3 2008 32. Registrar's Signature				

08-02707

Rachel Ellen Johnsen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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6	8 1	

		r- For State Registrar		Certifica	ale or	Deain					eg. No.		
Physicia edical Examir	n/ ier	1. Decedent's Name (First, Middle, Last Rachel Ellen	Johnsen						A	Date of Dea Month April 6, 20	Day 008	Year	3. Time of Death 0805 hrs
Dk		4a. Facility Name (if not institution, give Civista Medical Center	e street and number)		4	b. City, To La Pla		ocation of	Death			County of Dea harles	th
Funeral		Social Security Number 6. S	x 7. Age (In	yrs. last birt	hday)	If Under	_	If Under	_			Fore	Birthplace (State or
Director		218-25-7237	M 2X F	18	Yrs.	Months	Days	Hours	Min.	Octob	er 9	,1989	Country) Maryland
χ.	ļ	Usual Residence of Decedent 10a. State 10b. County	1100	. City, Town	or Locatio	00							10d. Inside City Limits
iow any	.	MD Charle		La Pi		017							1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		La F.	Lata	10f. Zip	Code				10g. Citiz	en of What Co	ountry?
th the Mary 23a or 28a- notified at		10980 Wallace B	owling Lane				206	46				USA	
death with the Maryland or items 23a or 28a-f she nust be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces?	r in U.S.		s Deceder es, specify				ify Yes or N can, etc.)	0-	Race - Am White, etc.	erican Indian, Black,
ter deal			1 Yes 2 X	No	1	Yes 2	X No	specify:				Specify:	White
136 thin 72 hours after ie. than "natural", edical Examiner	a b	15. Decedent's Education (Specify or	or Dates:		Decedent	t's Usual (Occupatio	n (Give ki			16b. K	and of Busines	s/Industry
16 n 72 ho nan "ns	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			ident	ang me. L	3011010	se retired	,		Co11	200
5-003 led withi Hygiene.	mo	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		500	dent	18	8. Mother's	Name (F	irst, Middle,	Maiden :		ge
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Lee Johnsen								.eave1			
O ge p is is	٩	19a. Informant's Name/Relationship (T Lee Johnsen/Fath										ty or Town, Sta 1 a t a . MI	ate, Zip Code) D 20646
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If iten 27 is n injury or other traumatic		20a. Method of Disposition		20b. Place	of Dispos	ition (Nam			-	Date			or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify.		St.]		ner place) Cius	Ceme	tery	4/10	/08	Po	rt Toba	acco,MD
altir rmit. P partme iportai		21. ig ature of Funeral Service Licen		945	22.	REHA	Address (CHOL'S	FUN	ERAL	HOME	.P.A.	20646
	_	23a. Part I. Enter the disease, or comp	ligations that sourced the	death Don	1 2	11 5	+ M	arvic	Δτο	Τa	Plat	a MD 4	20646 Approximate Interval
Physician Medical		failure. List only one cause on ea	ach line.	Qeatii. Do ii		ne mode c	n dynng, d	0011 00 00	10.00	30p.10101, a			Between Onset and Death
xaminer		Immediate Cause (Final disease a. or condition resulting in death)	Multiple Injuries Due to (or as a consequence)	ence of):									
	<u>.</u>	Sequentially list conditions, b.	Due to (or as a consequ	ance of):									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							_				
ecuted and transit		events resulting in death) Last d.	Due to (or as a consequ	ence of):									
ੂ ਜ਼ੜੀ ਨੇ	n/Medical	UNPENDED	AMENDED										
8760, tificate be ng physici as the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy		etal death	3	Ectopic	pregnanc	Ç y	230	d. Date of delive Month	very Day Year
Box 687 he death certific the attending p	sicia	past 12 months? 1 Yes 2 No 9 ✓ Unknown	4 Pregnant at tim	e of death	- =	ther (Spe	cify)						
D. Box t the death of by the atten ached for us	Phys	Part II. Other significant conditions	a Olikilowii	ut not resultir	ng in the u	underlying	cause gi	iven in Par	rt I.	23e. Did	I tobacco	use contribute	to the cause of death?
i, P.O. ires that the signed by I be detach	þ									1Y	es 2	No 3 F	Probably 4 VInknown
ords, w requir ls been s should 1	letec		-							24a. Wa	s an		autopsy findings available to completion of cause of
of Vital Records, gr Physician: The law require wher this certificate has been simeral director, page 2 should t	Completed										formed?	death	
tal Rection: The	Be C	25. Was case referred to medical examiner?	Uitali					of Death (
n of Vital Rec ding Physician: The I. After this certificate I funeral director, page	ļ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 X ER/0	Outpatient Time of			Other y at Work		Home 5		ence 6 O	ther:
on of nding Pl tth. r: After re funera	ion:	1 Natural 5 Pending	Apr 6, 2008		00 hrs	.,,.,		es 2 🗸	No S	ubject dr	iver of	motor vehi	cle that struck
Division tal or Attendi rs after death. al Director: /	ertification:	2 ✓ Accident Investigat 3 Suicide 6 Could not	28e Place of Injury	/ - At home,	farm, stre	et, factory	, office bu	uilding, etc			(Street a	and Number or	Rural Route Number, City
Divi	Cert	4 Homicide determine	(Openin) Iviajoi						-	te 488 nea	ar Hawk		ad, La Plata, MD
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the it		29a. Certifier 1 Certifying Physic one) 2 Medical Examine	ian: To the best of my k	nowledge, do	eath occu investiga	rred at the tion, in m	e time, da y opinion,	te and pla death occ	ce, and do	ue to the ca the time, da	ause(s) ar ite and pla	nd manner as : ace, and due t	stated. o the cause(s)
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.					e number					(Month, Day, Year)
		There IM	Xind To		0		O.C.N	и.Е. ^{О(}	CME		Apr	ril 7, 2008	
		30. Name and address of person who				444 =		ant D	Live = :=	MD 040	01		
185		Theodore M. King, Jr., MI	461			-		eet, Bal	ıtımore,	MD 212	UT		
St	tate	31. Date filed (Month, Day, Year)	2008 32. R distrar's	Signature	1	raile							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** March a M 0 2008 NATHAN KELLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director 249-18-9705 FEB 7, 1919 SOUTH CAROLINA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7758 FINNS LANE APT # B2 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 DYes 2 No ARMY If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Completed by BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th CUSTODIAN GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental I ant: If item 27 is marked o ALBERT KELLY COOK ALCIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health at Important: If item 27 Is any Injury or other trau JONATHAN KELLY/SON 7758 FINNS LANE APT B2 LANHAM, MARYLAND ath⊄n Baltimore, № 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 4/8/2008 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician athero unknown /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physiciar by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an has autopsy performed? this certificate 2 **N**o 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X**No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00055697 2008

State Registrar 8/18 Good LuckRd., Lanhan, mo. 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19n

3 2008

31. Date filed (Month, Day, Year)

APR 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** ŏÿ, Walter Michael Ам Keene April 2008 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 36830 Asher Rd. Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | 9 | 1949 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** North Carolina 58 231-68-6259 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Maryland St. Mary's Mechanicsville 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36830 Asher Rd. 20659 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter permit. Pages 1 and 2 should be filed: Department of Health and Mental Hygiis Important: If Item 27 Is marked other any inJury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Audrey M. Dorman Walter M. Kenne, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26750 Stone Corner Lane, Mechanicsville, MD 20659 Katherine Hatcher/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10 April 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., JASTER MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mondo /Medical Examiner Sequentially list conditions, if any leading L Examine burial-transi Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a Id be detached f 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 □Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Affer (Month, Day Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

death certificate be executed Box 68760, P.O. | Division or Vital Records,

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who complete ause of death (Item 23a) (Type, Print) P. Jarboe, James California, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

determined

4 Homicide

DHMH 17 Rev 1/2001

after

within 24 hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 4:35 p.m. April Beatrice Ellis Kregloh 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's Leonardtown St. Mary's Nursing Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 1□ M 2XF 0/29/1919 New York 88 108-16-9723 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No California Maryland | St. Mary's 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20619 United States 23140 Cobblestone Lane Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude Ellis Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23140 Cobblestone Lane, California, MD 20619 Dan J. Kregloh/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 04/15/2008 | Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee_ 22955 Hollywood Road, Leonardtown, MD 20650 M01206 Kyle S. Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) fasta (a Me Due to (or as a consequence of): FID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 Fetal death Day Year in the past 12 months? 1 ☐ Yes 2 XNo 5 ☐ Other (specify) 4□Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Examiner Division or Vital Records, P.O. Box 68760.

The law requires that the death certificate be executed use as the burlal-transi and the attending physician To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

"natural", or items 23a or

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
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Physician /Medical

Baltimore, Maryland 21215-0036

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Director

Funeral

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Examiner

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed To Be 25. Was case referred to medical examiner? 1 Yes 27. Mapner of Death Medical Certification: 1 Natural 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

47066

4.15-18

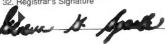
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22650 Cedar Lane Court, Legardtown, MD 20650 Avani D. Shah, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature



Proletrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL SUZANNE 200^{Year} KENNY 6, 4:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs Director 375-20-2259 81 June 20, 1926 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medit all Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 5516 Camelot Court 21704 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 2 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Batwell Sweet Florence Ella Vliet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seely Foley / Daughter 5516 Camelot Court Frederick, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 9, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 Dopation 5 Dother (Specify) Stauffer Crematory 2008 Frederick, Maryland 21. Si flature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herntitis **Physician** /Medical Due to (or as a consequence of) Examiner alcohol Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1□ Yes 2 NO Fo the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**∏**∕No 1 ☐ Yes 1 Dinpatient ို 2 □ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending after death.

I Director: A
d in by the fu investigation 1 ☐ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) 400 W ect Street 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 15:14 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F Days Months Hours Min. 3-38-746 Director TUNE 25, 192 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits CANADASCARBOLOWA 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ANAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOCTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Mental h and Menta RI ည permit. Pages 1 and 2. Department of Health an. Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418413 20a. Method of Disposition TideSWELL SCArBOROUGHONTARIO -SISTER BLVD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation Thorn HILL ONTAGIO 4,2008 July 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 635 ChurchMANSRD STrano + Feeley Funeral Home NewArk De dward 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4/6/08 Immediate Cause (Final **Physician** CARD: AC disease or condition resulting in death) /Medical Due to (or as a consequence of): 4/2/08 **Examiner** GUCEPHAZORATUS CARDIAL PROJEST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown care has been signed by topage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by PVD CAD CABG DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 140NES DISEAS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform INFECTION 1∐ Yes 2 No or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one) examiner's Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hosping.
within 24 hours after death.
To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON MD 2192 S PEACE. 160 CATURORO MARK 31. Date filed (Month, Day, Year) State 9 2008 Registrar

David Wyatt Lewis	1	r. - For State tegistrar	State	of Maryla		partment of ertificate of		d Menta	i Hygie		eg. No.	200	8	1324
Physician Medical Examine	/	1. Decedent's Name (First, David W) Lewis	Īν				l M	ate of Deat lonth oril 3, 20	Day	Year		e of Death 25 hrs
B.	•	4a. Facility Name (if not ins	stitution, give	street and nur	nber)		4b. City, Town, or Bladensbur				4c. C	ounty of Dea		
Funeral Director		5. Social Security Number unknown	6. Se	x M 2 F	7. Age (In yr:	s. last birthday) Yrs	If Under 1 Year Months Day		Min.	Date of Bir		944 G	ian	(State or lifornia
any	-	Usual Residence of Deced			10c. C	ity, Town or Locat	ion						10d. ln	side City Limits
ryland a-f show it once	3 1	Maryland Pr	ince (George's	5	Bladensb	urg 10f. Zip Code			T10	0a. Citizer	n of What Co		Yes 2 No
rith the Maryland 23a or 28a-f show any notified at once.	- L	4470 Blue	Heron				20	0710			Unit	ted St	ates	
ler death wir ", or items?"	5	11. Marital Status 1 Never Married 2 3 Widowed 4		12. Was Dece Armed Fo 1 Yes If Yes, Give Year	rces?	If Y	as Decedent of Hi 'es, specify Cuba Yes 2 X No	n, Mexican, P				Nace - Ame White, etc.		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiena Mental Hygiena 71 is marked other than "matural", or items 23a or 28a-f sho imjury or other traumatic event, the Medical Examiner must be notified at once To Bo Completed Hy Eumeral Director	Ompleted by	15. Decedent's Education Elementary/Secondary (Specify or	or Dates:	e completed		nt's Usual Occupa	ation (Give kin		done		d of Busines:		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	3	12 17. Father's Name (First, M	fiddle, Last)			La	borer	18.Mother's I	Name (Firs	st, Middle, I		onstru	ction	1
21215 ould be file d Mental H s marked it	ן ב	David W. Le				19h Mailin	g Address (Stre	Mary		Route Nun	nher City	or Town Sta	ate. Zin Co	nda)
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Baltimore, permit. Pages I ar Department of He Important: If ite		20a. Method of Disposition 1 Burial 2 X Cre 4 Donation 5 Ot	mation 3 [her <i>Specify:</i>		m State	bb. Place of Dispos crematory or of Stauffer	her place) Cremator	ry		17, 008	Free	cation - City derick	, Mai	ryland
Bal: permid Depar Impo		21. Ignatule of Funeral S	Jet			8	Name and Addres	eville	Blvd	. Mt	. Air	cal Ho	rylar	nd 21771
Physician /Medical 	١	23a. Part I. Enter the disea failure. List only one Immediate Cause (Final di	cause on ea	^{ch line.} Atheroscler	otic Cardi	iovascular Dis		, such as card	diac or res	piratory arr	est, shock	k, or heart		oximate Interval veen Onset and Death
,		or condition resulting in de Sequentially list conditions	b.	Due to (or as a										
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Box 68760, e death certificate be e the attending physicia ed for use as the burial burisicial buri	2	IF FEMALE: 3b. Was decedent pregna past 12 months? 1 Yes 2 No 9		23c. If yes, of 1 Live b	ant at time of	2 F	etal death 3 ther (Specify)	Ectopic p	oregnancy	_		Date of deliv	ery Day	Year
P.O. Bost that the degree by the detached for the bost the detached for the bost the		Part II. Other significant	conditions			ot resulting in the	underlying cause	given in Part	l.					use of death?
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ital Rician: 1		25. Was case referred to r examiner?	F	lospital:	npatient 2	ER/Outpatien		ce of Death (C	Check only Nursing Ho		Dooidon	ce 6 🗸 Otl		
Division of Vital I hin 24 housely and I hin 24 house after death. The return a fire death the Funeral Director: After this certify inpletely filled in by the funeral director, fired for the funeral director.		1 V Yes 2 N 27. Manner of Death 1 Natural 5	Pending	28a. Date (Month		28b. Time of	Injury 28c. Inj	ury at Work? Yes 2 N	280	. Describe			ier. Scene	,
Division o To the Hospital or Attending whith 24 hours after death. To the Funeral Director: After completely filled in by the fune		2 Accident 3 Sulcide 6 4 Homicide	Could not determine	be 28e. Place	e of Injury - A	At home, farm, stre	eet, factory, office	building, etc.	28f.	Location (or Town, §		Number or	Rural Rou	ite Number, City
To the Hos within 24 h To the Fun completely					of examination	rledge, death occu on and/or investiga								e(s)
F & F &		29b. Signature and title of	lorte	ul C)			se number				ate signed <i>(I</i>	Aonth, Da	y, Year)
2		30. Name and address of Laron Locke MD.	Assis	ant Medica	l Examine	er 111 Peni	n Street, Balti	imore, MD	21201					
Stat Registra		31. Date filed (Month, Day		008 32. Re	strar's Sigr	nature .	all)							
DHMH 17 Rev 1/200	1	OCI	ΛF	1	Application of the Parket	ORIGINA	AL.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 30 P M Alfred Pierce Landing, Sr. 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jewn, or Location of Death Coasted Hospice at the Lake Dallskur Wicamica If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 **X**M 2 □ F 219-34-4062 74 10/3/1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 300 Lemmon Hill 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify white 3 ☑ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salisbury Steel laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda McDorman Bozman Elvyn Gordy Landing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cindy L. Centineo/daughter 822 Outten Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Beechwood Membrial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 4/10/08 Princess Anne, MD 21. Structure of Function Service Licensee Holloway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Compson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of) MULTIPLE MYRLOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ₽₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f shov must be notified at

r than "natural", or Iten the Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglens Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once.

death with the

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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physician attending p certificate has b r this certifica After

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Certification:

<u>م</u> Completed Be မ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the Medical

State Registrar

27. Manner of Death Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier

8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

20058410

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPICA GHULHEN WARKS

31. Date filed (Month, Day, Year) APR 0 9 2008

32. Registrar's Signature ENGUE



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marjorie Joan Lofgren /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANAGUA REGIONAL SAUSBUY Mounia 6. Sex / If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 238 F Director 163-28-8083 England 9, 1924 Oct. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits **Funeral Director** 1XXYes 2 No MD Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8736 Bi State Blvd. U.S.A. 21875 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ Specify: 3 ₩ Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Conductress 8 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Richard Milton Minnie Goodearl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8750 Bi State Blvd. John Dana Lofgren (Son) Delmar, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 9, 2008 Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Sepsis immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perforn 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**2** No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

that the death certificate be executed burial-transit Box 68760. physician the for use as attending P.0. the ò Division or Vital Records, page 2 should been certificate After this funeral

28a-f show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event

Maryland 21215-0036

Baltimore,

Hospital or Attending the Funeral Director: After Sure fulled in by the fu

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the

person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

29c. License number D24872

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Pocomoke City MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MASSEY 03 27 FRANCES 2054 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL MONTOOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/13/1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🖺 F 70 Director 228-54-4340 Alabama Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show sdical Examiner must be notified at 1KIYes 2 □ No Director MD Prince Georges Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 USA 3001 Queens Chapel Road # 006 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: Specify: Black þ 3₺Widowed 4□Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical Once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Enviromental Specialist Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Calloway Lawrence Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Vincent Massey/Son 2301 11th Street N.W. #202 Washington, D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Lincoln_Cemetery 04/07/2008 | Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mongamey Cleation 3401 Bladensburg Road, Brent 23a. Part1. Where the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. 3401 Bladensburg Road, Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autonsy performe 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury 28b Time of To the Hospital or Attending Protin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 60319 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMMEN 7600 Carroll Avenue Takoma Park, MD 20912 31. Date filed (Month, Day, Year) State APR 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylan		rtmen				lental Hy	_	711	08	1324	15
	200	10	Decedent's Name (First, Middle, I	Last)			····		Journ		2. Date of D				3. Time of Dea	th
	Physicia		Lerov Mark I	McGuire							Month March	_	ay 2008	Year	4:49 P	M
	/Medic Examin		4a. Facility Name (If not institution, g		mber)		4b. City,	Town, or	Location		march			of Death		
			Southern Maryla	and Hosp	ital			into	n				Prin	ice G	eorge's	
	Funeral		Social Security Number 6	. Sex 1. T M 2. F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Yea		9. Birth	place (State or For ntry)	reign
No.	Director		525-66-7661 Usual Residence of Decedent		75	ris.					Feb 20	, 19	933	Crow	, Texas	
	/land ow at		10a. State 10b. County		10c. City	, Town or Loc	cation								10d. Inside City Lir	mits
	Many a-f sh ffed	ţo	Maryland Prince	George!		Clir	ton								1 X Yes 2 □]No
	or 28e	Director	10e. Street and Number	GEOLEE	D1	0111	10f. Zip	Code				10g. C	itizen of	What Cou	ntry?	
	th wil		11108 Willow Way	y Court			20	735				Uı	nited	Sta	tes	
	terns terns	Funeral	11. Marital Status	Armed Fo		S. 13. V	Vas Deced Yes, spe	lent of Hi	ispanic Oi n, Mexica	rigin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	0-		ce - Ameri ck, White	can Indian, etc.	
2	s afte	by F	1 ☐XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	2 □ No ve	1	□Yes	2 No	Specify				Specif	y: _		
3	hour tural		15. Decedent's	Year or D	ates:	16a. Deced	ent's Hsu	I Occupa	ation			16h		Cau usiness/fr	casian	
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7 7	d with giene ir tha the I	E	Elementary/Secondary (0-12)	College (<u>4 year</u> :		Direc	ctor	of H	uman	Serv	ices		Gov	ernm	ent	
2	al Hyg	Be	17. Father's Name (First, Middle, La								(First, Middle	e, Maide				
<u> </u>	Menta	၉	Silas McGuire						Mar	ud Do	nohue					
0	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. At them 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	,							al Route Numi					
≥ '`	s 1 and 2 Health tem 27 i	1 9	Tim McGuire -	Son	1				Way (Clint					
2	ges 1 If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	State C	lace of Dispos emetery, cren	natorý or o	ther plac	e) :	[Date	20c.	Location	- City or T	own, State	
	t. Pa tmen tant: ijury		4 Donation 5 □ Other (Spe		Lee	e's Cre					3, 20					
ם	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Si hature of Funeral Service 1	o ol	TITA						ewart NE Was				-	
1			23a. Part1 Finter the disease, or conshock of heart failure. List or	omplications that only one cause on e	caused the death	n. Do not ente	er the mod	e of dying	g, such as	s cardiac o	or respiratory	arrest,			Approximate Interval Between	n
i	Physician		Immediate e (Final disease or condition	,	Servi	Tic	ch	00	V						Onset and Deatl	h
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000	ficate physis the	edical		d												
X	n certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna								23d. Da	ate of deliv	rerv	
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'n	gned ge del	by P	Part II. Other significant conditions A	s contributing to d	eath but not resu	ulting in the un	derlying c	ause give	en in Part	I.	23e. Did	tobacco	use con	tribute to	the cause of death	1?
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زا	law r as be	ple		0							24a. Was	s an opsy	24b.		opsy findings avail	
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5	ding I	Certification:	27. Manner of Teath 1 Natural 5 Pending 2 Accident investigat		th, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	/at ⟨? Yes 2.[28d. Describe	how in	jury occui	rred		
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	ospita hours ineral y fille		29a. Certifier Certifying	Physician: To the	best of my know	wledge, death	occurred	at the tim	ne, date a	ind place,	and due to the	e cause	(s) and m	anner as	stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous after death. Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicat	(Check only 2 Medical Ex	caminer: On the b	asis of examina ner stated.	tion and/or inv	estigation/	, in my o	pinion, de	ath occur	red at the time	e, date a	and place,	, and due	to the cause(s)	
	5 time	Σ	29b. Signature and title of certifier	1			1		number	~ ^					Day, Year)	
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2	(10)		30. Name and address of person wh				Print)	11 -	c . 4	10	YIVE	-01	6		MO	
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			For State Registrar		State of	Marylan		artment rtificate				lental Hy	/gien Reg. N	éUUÖ 10.	1321	} /
			1. Decedent's Name	e (First, Middle, L	.ast)							2. Date of De	eath		3. Time of D	eath
	Physici /Medio		MTAMA	V.	McCLAIN						1	Month MARCH	2	5, 200) М
	Examir		4a. Facility Name (If	not institution, g				4b. City, T	own, or	Location	of Death		4	c. County of De		
			MANOR CA	RE NURS	ING HOME			SIL	ER	SPRI	NG			ONTGOME		
	Funeral		5. Social Security No		Sex 1 □ M 2X F	7. Age (In yrs. 5	last birthday)	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D MAR. 2	irth	r) 9. B	irthplace (State or I Country) BERIA	Foreign
	Director		116-46-00		1 M 220 F	, ,	Yrs.					MAR. 2	26,	1948 LI	BERIA	
	and		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation			-				10d. Inside City	Limits
	viarylan f show	ō	MD	MONTGO	WEDV.										1 XYes 2	
	28a-	rect	10e. Street and Nun		VIERI	51	LVER S	10f. Zip C	ode	_			10a. C	Citizen of What C	Country?	
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	death ms 2	era	11. Marital Status	OICOVII 10	12. Was Dece	dent Ever in U.		Was Decede	nt of Hi	ispanic Or	igin? (Spi	ecify Yes or N		14. Race - An	nerican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinational be mailined at once.	Completed by Funeral Director	1∭ Never Marrie 3 ☐ Widowed		Armed For 1 ☐ Yes If Yes, Give Year or Da	2 X No ∍		lf Yes, specif 1 □ Yes 2 <mark>x</mark>		n, Mexica Specify		Rican, etc.)		Black, Wh		
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Ω.	res that i igned by be deta		Part II. Other signifi	cant conditions	contributing to dea	ath but not rest	ulting in the u	nderlying cau	se give	en in Part	l.	23e. Did	tobacco	use contribute	to the cause of dea	ath?
Records,	w requires been sign should be	sted by		Mo	ORBID C	BESITY						1 🗆	Yes 2	2 □ No 3 □ F	Probably 4XUnl	known
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referre	ed to medical	1						e of Death	(Check only	one)			
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	Sta Registr		31. Date filed (Mont)		32. Re	gistřar's Signat	ture		البادعة	~ · · · · · · · · · · · · · · · · · · ·		<i></i> ↓↓↓				

DHMH 17 Rev 1/2001

dical	1	Registrar Decedent's Name (First, Middle) Thelma M.				rtificate o			2. Date of Dea Month	Day	Year	3. Time of Death
niner	4:	a. Facility Name (If not institution,		mber)		4b. City, Town			April	4c. Coun	nty of Death	
ing.		Golden Living C	Center 6. Sex	7 Age (In yes	s. last birthday)		inster		8. Date of Birtl		arrol]	
al or		203–16–9027 A Usual Residence of Decedent	1 M 2 K F	84	Yrs.	Months Day		Min.	Mar 12	Year924	Peni	place (State or Foreign ntx) ntxylvania
ctor		0a. State 10b. County Iaryland Carr	coll	10c. C	city, Town or Lo		Finksh	ourg				10d. Inside City Limits 1 ☐ Yes 2 🕱 No
Funeral Director	2	0e. Street and Number 201 Old Westmin	nster Pike	e #9		10f. Zip Code	21	048		10g. Citizen o	of What Coul USA	ntry?
þ		Marital Status Never Married 2 Marrie Midowed 4 Divorced	Armed Fo	2 📉 No ve		Was Decedent of If Yes, specify Co 1 ☐ Yes 2 🗷 N			cify Yes or No- Rican, etc.)	14. Ra Bl	ace - Americ lack, White, cify: V	
Completed	-	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti ensed Nu	ne during mos red)	st of workin	ng	16b. Kind of Hea.	Business/In	•
To Be C	1	7. Father's Name (<i>First, Middle, I</i> Alvie Byro r							(First, Middle, Coleman		ame)	
	1	19a. Informant's Name/Relationsh Jacqueline Hahr		er		ng Address (Stre						^{o Code)} MD 21048
	2	0a. Method of Disposition 1 Ma Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State La	wn Haw Burial	osition (Name of matory or other p Estates	olace)	4/9/2		20c. Location Kittan	ning,	PA
ouce.	2	21. Signature of Funeral Service I	icense	ture		2. Name and Add						
n al	1	23a. Part1 Enter the disease, or shock, or heart failure. List of the control of	only one cause on	caused the dea	ath. Do not en	ter the mode of d	ying, such as	s cardiac oi	r respiratory ar	rest,		Approximate Interval Between
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by Physician/Medical Examiner	Silver of the second of the se	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No	b. Due to c. Due to d. 23c. If yes, out 1 Live to 4 Pregri	(or as a conse	quence of): nancy tal death 3[death 5[☐ Other (specify)	ncy	los.	uds	23d. E	Date of deliv Month	20 y
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Certification: To Be Completed by Physician/Medical Examiner		Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d. 23c. If yes, out 1 Live to 4 Pregreg 9 Unkn ons contributing to do ation ot be ned 28e. Place build g Physician: To the Examiner: On the b	(or as a consectome of pregion of the consection	nancy tal death 3 [death 5 [sulting in the u 28b. Time o Injury]	other (specify) Inderlying cause of the second sec	26. Plac Other: 4 Nijury at Jork? Yes 2	e of Death ursing Hon 2	23e. Did to 1 24a. Was autopperform 1 Yes (Check only one 5 Residence City or Towns and due to the end of the control of	23d. E	Date of deliv Month 3 Prol b. Were autoprior to condeath? 1 Yes Other (Special urred)	ery Day Year the cause of death? bably 4 □Unknowr Dopsy findings available popletion of cause of 2 □ No fy) al Route Number,
To Be Completed by Physician/Medical Examiner	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Sequentially list conditions, it any, leading to immediate ause. Enter Underlying Cause (Disease or Injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d. 23c. If yes, out 1 Live to 4 Pregr 9 Unkn ons contributing to do ation of be ation of be 28e. Place build g Physician: To the Examiner: On the b and man	(or as a consectome of pregression of the pregressi	pquence of): pq	other (specify) Inderlying cause of the second of the sec	26. Plac Other: 4 Nijury at Jork? Yes 2	e of Death ursing Hon 2 3 No 2 and place, a ath occurre	23e. Did to 1 24a. Was autop performed to the control of the cont	23d. En Moore 24th Normed? 22 No ne) dence 6 □ O now injury occion occion (street and Num, State) cause(s) and indicate and place.	Date of delive Month The prior to condeath? Other (Special urred) The prior or Runner as see, and due to the Month, and the prior to condeath?	ery Day Year the cause of death? bably 4 □Unknowr Dopsy findings available popletion of cause of 2 □ No fy) al Route Number, stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Walter Stauffer Martin 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) March 30,1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Min. Months Days Hours 1₱M 2□F 82 Yrs Pennsylvania 900-28-1949 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Maryland St. Mary's Leonardtown 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 USA 26602 Pt. Lookout Road Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married 21215-0036 'natural", or 1 ☐ Yes 2X No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Furniture Store Furniture Repairman 8 is marked other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be and Mental Pages 1 and 2 should be Wilson Martin Sarah Stauffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Item 27 i 26606 Pt. Lookout Road Harlen Martin / Son Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot April 15 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loveville Mennonite Loveville, Maryland 2008 4 □ Donation 5 □ Other (Specify) Cemetery 21. Signature of Funeral Service L 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Tress Syndems death certificate be executed burial-transit that initiated events resulting in death) Last and P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, be þ ENPLY SIVE Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has HERO Sel EROFIE Candedorscular Dis Ease this certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 ☐ Accident investigation death. filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely

State Registrar

Medical

29a. Certifier

(Check only one)

Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

Box 186 MECHANICS VIlle Maryland KoAchs 32. Registrar's Sign 31. Date filed (Month, Day, Year) 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

015027

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . ^{Day} 2008 April 17, Physician Mary Ann Miss 2:30 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1306 Pinewood Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 5, 1935 Birthplace (State or Foreign Country) Social Security Number 214-30-1763 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 73 1 □ M 2 1 X F Delaware Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1306 Pinewood Drive 21701 United States Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert N. Bell Grace Pokoiska 2 19a. Informant's Name/Relationship (Type. Print)
Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Pinewood Drive, Frederick, Maryland 21701 Roger Stull Representative 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 18. permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licer 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7-10 Days Pheumonio /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown jo 5 Other (specify) detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy page performed? Yes 2X No certificate or Attending Physician: ector, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this (5 Residence 6 □Other (Specify) funeral dir 28a. Date of Injury 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check or one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5hah Hirch N an D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) redonices mn d1702 1 homas Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DEBRA LYNN MOTHERSHEAD APR.14,2008 7:14P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE SOUTHERN MD.HOSP.CENTER CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 8, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F 55 8,1952 WASH.,D.C. Director 579-70-7313 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 □Yes 2√2 No Director MD. CHARLES WHITE PLAINS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be USA 4844 SMITTY CIRCLE 20695 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □ Yes 2 □ No If Yes, GiveX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GREENLEE MONEYMAKER PATRICIA BEAN Item 27 is marked ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERT M.MOTHERSHEAD-SPOUSE 4844 SMITTY CR. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) ö 3 □Removal from State OAKLAND CÉMETERY permit. Page Department of Important; If any injury or 4-18-08 WALDORF,MD. 21. Signature of Funeral Service Licensee 2. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wheoso Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Known 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes ASTELLA 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 1 Impatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft

To the Funeral DI

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature

CVINGSTON ROAD 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

350 Fortasky Tu MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 10:35am ^M Apr 16, 2008 Mortzfeldt Adele Shirlev /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 402 Fayette Street 8. Date of Birth (Month, Day, Year) Apr 28, 1920 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months MD 87 215-14-6346 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Medical Examples 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Cumberland Allegany MD Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 402 Fayette Street Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 🔏o Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Water Department laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Castle Frederick Mortzfeldt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WV 26726 Rt. 2 Box 210 Keyser Linda Thompson cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/21/2008 MD Sunset Memorial Park Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature Fundral Service Lice 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ORONAR Immediate Cause (Final disease or condition resulting in death) ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performe 2□No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signat

30. Name and addre

31. Date filed (Month, Day, Year) APR 2 3 2008

MEMORIPZ 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

HOSPITA

29d. Date signed (Month, Day, Year)

CLIMBERIAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2008 April 11, 12:53_{P M} Marie Frances Nelson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2K F 217-68-7043 August 4, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Leonardtown Maryland St. Mary's 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40585 Eddie Nelson Road 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify. 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Edna Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Son P.O. Box 123 Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 15, St. Aloysius Cemetery Leonardtown, Maryland 2008 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 uckrael e of dying such as cardiac or respiratory arrest Approximate Interval Between Onset and Death as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Day Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-

al Hygiene.

if Health and Mental I item 27 is marked of

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n

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any Injury

Director

Funeral

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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The law requires that the death certificate be executed attending physician and burial-trai the signed by certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

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Physician/Medical	
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Be Benjamin Franklin Adams 19a. Informant's Name/Relationship (Type. Print) James Edwin Nelson, Jr. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last xaminer IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2∏No 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and ty e of certifier 29c. License number D06419 cause of death (Item 23a) (Type, Print) ess of person who comple 24035 Three Notch Road Jarboe, /D. Hollywood, MD 20636

Registrar

State

32. Registre's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Pieter Oskam 2:25 April 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□F Days Yrs Director 574-10-6851 76 Oct 14 1931 Netherlands Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant the status. 10a. State 10c. City, Town or Location 10d, Inside City Limits MD Director Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Clubside Drive 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1956 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Tyes 2 □ No Yes, Give Baltimore, Maryland 21215-0036 1957 1 ☐ Yes 2 ☐ No Specify. White þ Specify. 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Management Agway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Teunis Oskam Isabella van Bergan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Oskam/wife 120 Clubside Drive Taneytown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 04/0772008 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 4 Donation 5 Dother (Specify) Hampstead, MD 21. Signature of Funeral Service 22 Name and Address of Facility Pritts Funeral Home and Chapel, P.A. Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between onset and Death Immediate Cause (Final Physician MUS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4, Honom Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2₽No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6-Other (Specify) Douc House 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After WJZ

State

Registrar

Medical

29a. Certifier

29b. Signature

and title of certifier

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5 South Center Street Liestyllister, MD 21157 14010 Mita 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, rint) Alan L. Carroll M.D. 310 South Seton Ave. Emmitsburg MD 21727 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		spitei ours e lers! [29a Certifier 156 Certifyi	ing Phy	sician: To th	a heet of	my know	lad in death	and wood at the time	no data and line	no. and due to the		el and manu	e ac et	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day PHILLIPS 2 NAIVIV 64 05 08 4a. Facility Name (If not institution, give street and number) Carroll Hospice Dove House 4c. County of Death Carroll 4b. City, Town, or Location of Death Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 6, 1924 9. Birthplace (State or Foreign Months Min. 1 □ M 2 🛪 F 83 Days Hours Mary land 219-14-8134 Vrc Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Taneytown Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 151 W. Baltimore Street USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2X No Specify: Specify: white 3XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rubber Co. Clerk/Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elma Zentz Howard Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4868 South 28th St, Arlington, VA 22206 Cherie Barnett, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Taneytown, MD Trinity Lutheran Cem. 4/9/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumation.

Physician

/Medical

Examiner

Director

Funeral

2

Completed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

Maryland 21215-0036

Baltimore,

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death certificate be executed

Division or Vital Records, P.O. Box 68760,

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

29c. License number 29b. Signature and title of certified 29d. Date signed (Month. Dav. Year) D-14317 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

TANEYTOWN

MD

21787

R. LINTHICUM M.D.

ONE KINGS DRIVE

31. Date filed (Month, Day, Year) 32. Regiarar's Signature

APR 0 9 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deal 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 15 2008 8:30 Pritchard Apri1 Perry E 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's 26256 Gardiner Court Mechanicsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 XM 2 ☐ F Months Days 74 523-36-2522 December 25, 1933 Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Mechanicsville Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20659 USA 26256 Gardiner Court 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman/Buyer Industrial Supplies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sadie Scadden Pritchard Arvada Albert Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26256 Gardiner Ct., Mechanicsville, MD 20659 Rickey Pritchard/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/16/2008 Brinsfield-Echols Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Brinsfield Echols Funeral Home, P.A. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 30195 Three Notch Rd., Charlotte Hall, MD 20622 disease or condition resulting in death) Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. s case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 BResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation

Physician /Medical Examiner

> as the burial-transit and

attending physician for use as the buria

been signed by the a

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after death. Hospital or Attending

within 24 hours a To the Funeral I

To the I

director.

filled in by

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the M-dical Examiner must be a

within 72 hours after death

filed withir Hygiene.

es 1 and 2 should be fil of Health and Mental H f item 27 is marked oth

Pages 1 a nent of Hea ant: If item

permit. Pages Department of Important: If it any Injury or or

Maryland 21215-0036

Baltimore,

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Funeral

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Completed

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Certification: To

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Thomicide

29b. Signature and title of certifie

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Pritchett, MD

6 Could not be determined

LaPlata, Maryland 20646

State Registrar 31. Date filed (Month, Day, Year)



and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:55AM 06 July 1 04 2008 enie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbier Wicomico er's Head Hospital Ceciter If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 **X**M 2 □ F 213-24-0360 Yrs. 82 Director 12/31/1925 North Carolina Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
and it Health and Mantal Hygiene.
ant: if Items 23s or 28s-1 show and it is the 23s or 28s-1 show and it is the analyon other traumatic event, it is histocial Exercities from the invilled at 1 ☐ Yes 2 No Maryland Wicomico Salisbury Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1227 Johnson Road 21804 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) maintenance poultry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bullar Luffman Charles Pruitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Ruxton Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Julie Wagner/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Springhill Memory 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. 4/11/08 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service 22. Name and Address of Facility Holloway Funeral Home Professional Association Vert 1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final erebral hemorrhage with severe countive and **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of). impairment. Examiner renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed . Arterios devotic cardiovas cular discase that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. luchia Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached? 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown ypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No certificate 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 _ fnpatient 2 _ ER/Outpatient 3 _ DOA Other: Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: And in by the fr 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours efter Fo the Hospitel within 24 hours of To the Funeral 29a. Certifier 1<mark>€ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40066064 04-07-2008 191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONY GONSALVES, D.O. DEERS HEAD HOSPITAL CENTER, Salisbury, MB 21802 egistrar's Signature 31. Date filed (Month, Day, Year) APR 0 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2008 Month **Physician** p_{M} 2:59 April 6, Raymond Η. Porter, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4731 Tyaskin Road Tyaskin Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 64 219-42-8110 Director 9/20/1943 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Me Ical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Tyaskin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21865 USA 4731 Tyaskin Road Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. Amed 1 decided 1 Mayes 2 do No If Yes, Give Army Year or Dates Army filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify. white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Broker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond H. Porter Sr. Dorothy E. Roe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Porter/wife 4731 Tyaskin Rd., Tyaskin, MD 21865 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 4/8/08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Censes ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cance disease or condition resulting in death) /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate curse. Uncompared to the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if the conditions of the Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Hospital: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

State Registrar

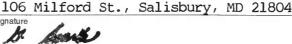
Dr. Christjon Huddleston 31. Date filed (Month, Day, Year) APR 0 9 2008

releterson MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signature



29c. License number

029105

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Michael Piasecki Jr. 7, 2008 4:15 $\mathbf{a}^{\!\!\!M}$ April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 764 Ocean Parkway Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days Hours 1 X M 2 □ F 1/2/1921 87 Maryland 217-16-3958 Director Usual Residence of Decedent : 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Berlin Director Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 764 Ocean Parkway 21811 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accountant accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Piasecki Anna Skoczynski ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum once. 764 Ocean parkway, Berlin, MD 21811 Doris Piasecki/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4/12/08 Resurrection Cemetery 4 □ Donation 5 □ Other (Specify) Levittown, PA 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Lie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MesotheliomA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by page 2 should be 4 Unknown 2 No 3 Probably 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has perform 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 ☐ Yes 1 🔲 Inpatient After this 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 11🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HU053714 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 Franklin Are Suck 302 31. Date filed (Month, Day, Year) State APR 09 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0609 er sole 2008 Henri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rec ester Hospital yrs. last birthday II Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. If Under Birthplace (State or Foreign Country) **Funeral** 25-8308 12M 20F Days Min. Months Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at 1 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ altimore, Maryland 21215-0036 1 Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☑ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Hy (901+ -Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be Item 27 is marked o John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 20746 tarker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H important: if Ite eny injury or ot once. 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 2008 Vewark 4/12 permit. 21. Signature o Funeçal Service Licensee 22. Name and Address of Facility Bennie KID 21801 tunera Duith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death letastati Immediate Cause (Final Physician disease or condition Tras /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) 68760 Physician/Medical Box → IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy this certificate 2/2 No Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 200 No 2 LER/Outpatient 3□ DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Heylung Farrect Island, De 19944 1209

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23ptII per me 8879 5-5-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 4 30 AM Rosa Lee Rothe HPRI 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE SINAL HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 ☐ M 2 💢 F 78 Yrs. 1, 1929 218-26-5106 New York Aug. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 X No Hampstead if item 27 is marked other than "natural", or items 23a or 28a-f sh or other traumatic event, the Medical Examiner must be notified Maryland Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21074 4420 Black Rock Road, Apt. 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married white 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Ruth France Edgar Buell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Albright Drive Hanover, Pennsylvania 17331 permit. Pages 1 and 2 Department of Health a Important; If Item 27 Is any injury or other trai Deborah Lamb - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Druid Ridge Cemetery April 9, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072|934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PLUTE MYDEAROIAL resulting in death) /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MICHER EX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent prognant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 1☐ Yes ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes METABOLIC ALIBOSIS 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No RESECTION 24a. Was an for Lung Cancer autopsy performed 2 No or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗂 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

WIL

Registrar

DHMH 17 Rev 1/2001

State

SHARON L

31. Date filed (Month, Day, Year)

APR 09

SINAL

32. Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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BALTMORR

2401 W. BEVENERE AVE.

		State	of Maryland / Depa	artment of H rtificate of L		, ,	0000	10000
-		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Tillicate of L	Jeani	2. Date of Death	g. No. 2	3. Time of Death
. Physicia /Medic		Jeannette Remsbur	g			Month April	Day Year 15 2008	2:00 P M
Examin		4a. Facility Name (If not institution, give street and r Frederick Memoria	umber) 1 Hospital	4b. City, Town, or Frede			4c. County of Death Frederic	
Funeral Director		5. Social Security Number 233-60-3148 6. Sex 1□ M X□ F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/03/1	Year) 9. Birth Con 941 Mary	pplace (State or Foreign intry) 1and
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryl -f sho fied a	tor	Maryland Frederick	Freder	rick				1 □ Yes 2 No
th the or 28a e noti	Director	10e. Street and Number	110001	10f. Zip Code		10	g. Citizen of What Co	untry?
ath wi		6903 Plantation Road		2170			nited Stat	
ter de items	Funeral	Armed	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
urs af	by	3 Widowed 4 Divorced If Yes, Year or	Give	1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	ite
72 ho 72 ho "natur dicai	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupa	luring most of worki		6b. Kind of Business/I	ndustry
within ene. than he Me	ршс	Elementary/Secondary (0-12) College	(1-4or 5+) cler	DO NOT use retired)		MD State g	overnment
e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)	LICI	L.K.	18. Mother's Name			OVERTIMETTE
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inimportant: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ToE	Ralph Charles Davis			Mary Hi			
d 2 sh thand thand 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		•			City or Town, State, Z	ip Code)
s 1 an f Heal item 2 other	1	Dennis C. Remsburg / s 20a. Method of Disposition	20b. Place of Dispo		, ,		MD 21758 20c. Location - City or	Fown, State
Page nent o ant; If ury or		1	Middletov	wn Luthera	an Cem. $04/1$		Middletown	
permit. Departi		21. Signature of Funeral Service Licensee				-	sford Fune	
40240		23a. Part1. Enter the disease, or complications that					ederick, M	Approximate
Physician		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	each line.					Interval Between Onset and Death
/Medical		reculting in death)	o (or as a consequence of):	, , , , ,	3 1 6			
Examiner	<u>.</u>	Sequentially list conditions, b.	o (or as a consequence of): MALL Co (or as a consequence of):	rary 1	-i brodi	5		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Small c	ell Li	ing C	A		
cate be executed oblysician and the burial-transit			o (or as a consequence of):					
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leath certific attending p	/Ме	IF FEMALE: 23c. If yes,	outcome pf pregnancy				23d. Date of deli	verv
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	e birth 2 ☐ Fetal death 3[gnant at time of death 5[□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
ss that gned b	by Pł	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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tysicie iis cert direct	o Be	examiner?		nt 3 DOA Othe	or:		nce 6 ☐Other (Spe	cify)
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vttend death. ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Pla	ce of injury - At home, farm, st		Yes 2 No	28f. Location (Str	reet and Number or Ru	ral Route Number.
tal or As after al Dire	Certification:	4 ☐ Homicide determined bu	ilding, etc. (Specify)	,,		City or Town	, State)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1						
To the within To the comp	M	29b. Signature and title of certifier	in M)	29c. Licenso	9 number 0 35/6	29	Od. Date signed (Monti	n, Day, Year) 2008
		30. Name and address of person who completed ca						
Sta	te.	Dr. Myung Hee Nam / 40 31. Date filed (Month, Day, Year) 32	O West 7th Str Registrar's Signature	reet, Fred	lerick, M	D 21701		
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		negistrar Decedent's Nam	e (First, Middle	e, Last)		_		Sitinoato oi	Doan		2. Date of De	Reg. No eath	0.200	3.	Time of Death
. Physicia /Medic		SHELTON	M. SUT	ron, Jr							Month 03/24/	_{D:} በጸ	ay Yea		42 P M
Examin		^{4a, Facility Name (1} 4249 58T						4b. City, Town, BLADENS		of Death	03/24/	4	c. County of D	eath	
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with ta or 2		10e. Street and Nur 4249 58T		ADT #1	1			10f. Zip Code					itizen of What	Country?	
leath ns 23 musi	Funeral	11. Marital Status	H AVE.	12. Was	Decedent	Ever in U.S	S. 13	20710 B. Was Decedent of	Hispanic C	Origin? (Sp	ecify Yes or N	USA o-	14. Race - A	nerican Ir	ndian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Marr		ied 1 🛛	ed Forces? Yes 2 ☐ es, Give r or Dates:	No NAVY		3. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No			Rićan, etc.)		Black, W Specify: B]		
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sho ld be tnd N ental s marked c umatic eve	To B	SHELTON	SUTTON,	SR.					BER	NICE	COLEY				
2 sho and N is ma		19a. Informant's Na	ame/Relationsl	nip (Type. Prin	rt)		19b. Ma	iling Address (Stree	t and Num	ber or Run	al Route Numb	er, City	or Town, State	e, Zip Cod	de)
and and and n 27 in 27 iner tra		ISHMAEL		ON/SON			1130)8 ELYSSE	DRIV			1D_2	0735		
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Pac tmen tant: jury		4□Donation	5 Other (S	pecify)		FT.		COLN CEMET			1/2008		ENTWOOL	, MD)
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To the Hospital or Attending Physician: The law requires that the death certificate be evitin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 0 9 □ Unknown	months? ☐ No	1	es, outcome Live birth Pregnant a Unknown	2 🗆 Fetal	death 3	B⊟Ectopic pregnanc	су				23d. Date of Month	delivery Day	Year
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e Hospital or Attenc 24 hours after death Funeral Director: etely filled in by the t	Certification:	3∏ Suicide 4∏Homicide	6		Place of inj building, et	ury - At hoi tc. <i>(Specify</i>	me, farm, :	street, factory, office	1		28f. Location City or To	(Street a wn, Sta	and Number or te)	Rural Ro	ute Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)	1 🔀 Certifyin 2 🗌 Medical	Examiner: On	To the best the basis of manner st	of examinat	vledge, de ion and/ø	ath occurred at the investigation, in my	time, date opinion, d	and place, eath occur	and due to the red at the time	cause(s) and manner nd place, and o	as stated due to the	i. cause(s)
To the within To the comple	Me	29b. Signature and	title of certifier	7	A		. 0	29c. Licen	se numbei	r			ate signed (Mo		Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month-10:55 AM Edward Charles Siford 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** County of Death Tre System
7. Age (In yes last birthday) 17 Maryland If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Hours Year, Yrs. 218-46-9445 60 Director June 1947 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Widcal Eventine must be profitted at once. Director 1XYes 2 No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Susquehanna Avenue 21903 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1966–68 1 □Yes 2 X No þ 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mount Aire of Delmarva Elementary/Secondary (0-12) College (1-4or 5+)
Two Years Dispatcher Shelby, Delaware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John B. Siford Naomi Baker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malinda Siford (Daughter) 2723 Arbutus Avenue, Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 04/09/08 4 ☐ Donation 5 ☐ Other (Specify) West Chester, Pennsylvania 21. Signature of Funeral Service licensee 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Day signed by the ad be detached for 5 ☐ Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No has 24a. Was an autopsy performe his certificate his director, page 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To the Hospira.

within 24 hours after death.

To the Funeral Director: After this c Hospital: 1 Yes 2 No Certification: To 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Box 68760 certificate be P.0. of Vital Records, Physician:

Baltimore, Maryland 21Ž15-0036

HVA

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2039(

29d. Date signed (Month, Day, Year)

Nealth Care System, Perry Point, mo 21902

			For State Registrar	State of Ma	ryland / L		rtificate of	leaith and M <i>Death</i>	lental Hy	giene Reg. No	0000	13261
	Physici	an	1. Decedent's Name (First, Middle, La	_					2. Date of Do Month 4/7/2		y Year	3. Time of Death
	/Medic		Janice Marie Ste 4a. Facility Name (If not institution, gi				4b, City, Town, o	r Location of Death	4///		. County of Dea	11:20 A
	Examin	er	5305 Sylvan Circ				Mt. Air				Carroll	
#4.00	Funeral Director	50	217–38–7433	Sex 7. Age	(In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 6/18/	rth a <i>y, Year)</i> 1941	9. Bir	thplace (State or Foreign buntry) D.C.
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	ith the	Director	10e. Street and Number	_	-		10f. Zip Code			10g. Cit	izen of What Co	ountry?
	eath w		5305 Sylvan Ci	rcle 12. Was Decedent E	iver in II S	13 1	2177		ooify Voc or N		USA 14. Race - Ame	erican Indian
136	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes No No No No No No No No No N			f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	0-	Black, Whit	
5-0036	72 ho 'natur dical l	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a	. Deced	lent's Usual Occup	eation during most of work d)	ing	16b. K	ind of Business	/Industry
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la J	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship					and Number or Run				Zip Code)
ა ე	1 an Heal em 2 ther		George J. Stelm 20a. Method of Disposition	acn/Husband			sition (Name of	ircle, Mt			∠I//I ocation - City or	Town State
saitimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cemete	icha	natory or other place nels R.C.	Cemetery		Pop]	lar Spri	ings, MD
gall	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee				teerr Fune				
			23a. Part1. Enter the disease, or con	nplications that caused	the death. Do			ld Libert			.ieia, M	Approximate
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final		9.7	19. 202	TOMH	.,	,	,		Interval Between Onset and Death
١.	/Medical		disease or condition resulting in death)	a. MeTAS1 Due to (or as a	consequence		10000					-maing
	Examiner	L	Sequentially list conditions,	b		-6-						
	rted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to jor as a	conse quence	orj:						
oʻ.	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence	of):						
58/6U,	ate be hysicia he bur	edical		_ d								
	:= D &		IF FEMALE:	23c. If yes, outcome p	of pregnancy							
o D	requires that the death certifi een signed by the attending nould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 🗀 Fetal déath		Ectopic pregnancy Other (specify)	у			23d. Date of de Month	Day Year
S	t the c by the	hysi	9 Unknown	9□Unknown								
S,	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death bu	t not resulting i	n the ur	nderlying cause giv	en in Part I.			_	o the cause of death?
ecords,	requii	eted										robably 4 ∐Unknown
e L	The law i ate has be page 2 sh	Completed								opsy formed?	prior to death?	utopsy findings available completion of cause of
VITAI			25. Was case referred to medical	<u> </u>				26. Place of Deat	1 Yes	2D No	1 ☐ Yes	3 2 No
_		To Be	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatier	nt 2□ER/Ou	utpatien	t 3 DOA Oth				6 ☐Other (Spe	ecify)
0	ding Phys 1. After this funeral di		27. Manner of Death 1	28a. Date of Injur (Month, Day	Year) 28b.	Time of Injury	Wor	rk?	28d. Describe	how inju	ry occurred	
UIVISION	tent tor: the	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	e 290 Place of inju	rv - At home, fa	arm. str	M 1 □ eet, factory, office	Yes 2 □ No	28f Location	(Street a	nd Number or B	ural Route Number.
2	al or A s after If Dire	Certification:	4 ☐ Homicide determined	building, etc		,	, , , , , , , , , , , , , , , , , , , ,			wn, State		ara. Froato Francisco,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier 1. Certifying P (Check only one) 2 Medical Exa	hysician: To the best o miner: On the basis of and manner sta	examination ar	e, death nd/or in	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the	e cause(s	s) and manner a d place, and du	s stated. e to the cause(s)
	To the within to the complex c	Me	29b. Signatur, and title of certifier	111	er er		29c. Licens			29d. Da	ate signed (Mon	_ ^
}	Jet 1		1/11/11/45 Kg	e411/40161	MIS			3509		Hpc	118	2008
 	6		30. Name and address of person who NIC Holas Kowfc	completed cause of de	ath (Item 23a)		Print) Phy	Colum	his m	Mry/	ano Z	1044
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 8 2	32. registra	r's Signature	A	asti s			7.		
DHI	MH 17 Rev 1/2		MIN O O L			500						

DHMH 17 Rev 1/2001

			1 - State Registrar		Cer	tificate (of L	Death			Reg. N	lo. 9 (A A	1326
e de la companya de l	Physici	an	1. Decedent's Name (First, Middle, Last)	~						2. Date of D		ay	Year	3. Time of Death
**	/Medic		FRANCES REGINA	SEL	TZER					April	4,	, 20	80	10:15 P ^M
	Examir	er	4a. Facility Name (If not institution, give street and number)	_		4b. City, Tov			of Death		4	lc. County		-
40	Funeral		Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (al (In yrs. las:	t birthday)	Fred If Under 1 Y	'ear	If Under 2		8. Date of E	Birth		ericl 9. Birth	place (State or Foreign
	Director		1□M 2 % F	64	Yrs.	Months Da	ays	Hours	Min.	(Month, I Aug 9	Day, Yea , 194	43	Mary	<u>n</u> try)
	P .		Usual Residence of Decedent											
	arylar show d at	_		10c. City, 1	Town or Loc	cation	шh	urmon						10d. Inside City Limits 1 ☐ Yes 2 ▼No
	he Mark	ecto	Maryland Frederick			1		uriion	IC 		T ::			
	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 16166 Kelbaugh Road			10f. Zip Co	de	2178	8		10g. C	Citizen of V	what Coul ISA	ntry?
	ns 23	era	11. Marital Status 12. Was Decedent Ev.	er in U.S.	13. V	Vas Decedent Yes, specify	t of Hi			cify Yes or N	10-			can Indian,
20	or iter		Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No						ĭ, Puèrto F	Rican, etc.)			ck, White,	etc.
ğ	ral", c	l by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1	□Yes 2 ✓	No	Specify:				Specify	wh.	ite
21215-0036	72 h 'natu dical	Be Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give I	ent's Usual O kind of work d OO NOT use re	ccupa lone d	ation Juring most	t of workin	g	16b.	Kind of Bu	usiness/In	dustry
121	vithin han ' e Me	E I	Elementary/Secondary (0-12) College (1-4or 5+)		life. D	ю мот use re Baker	etired) -			,	Food	Som	ico
N D	Hygie Hygie ther i	ပိ	17. Father's Name (First, Middle, Last)			Daker	\neg	18. Mother	r's Name	(First, Midd				106
an	d dal		Unknown							R. Mil		on Carrian	10)	
Maryland	2 should and Men Is marker aumatic	P	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (St	reet a					or Town.	State. Zit	Code)
	s 1 and 2 should of Health and Men item 27 Is marke other traumatic		Thomas W. Seltzer, Sr, husba	1		Kelba								
คั	es 1 a of Hei		20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name o	of r plac	e) :	Da	ate	20c.	Location -	City or To	own, State
Ĕ	Pages nent of int: If its iry or o		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			ny's C∈			/8/2	800	Emr	nitsb	urg,	MD
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee			Name and A								
<u> </u>	e e e e		Justi K. Durbon			210 W.						urg,	MD 2	1727
			93a. Part. Enter the disease, or complications that caused the mock, or heart failure. List only one cause on each line.	ne death. I	Do not ente	r the mode of	f dyin	g, such as	cardiac o	respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Septi	<u> </u>	had								Oriset and Death
Por .	/Medical Examiner		Due to (or as a d	conseduer	nce of):	to 0	. 6.2	0 0 1						\
	参	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequer	ck J LS	wy (ell	Perleti	<u></u>					hour.
	nsit	mìne	Cause (Disease or Injury		100 0.7.									
,	n and ial-tra	Examiner	that initiated events c	consequer	nce of):									
68/60,	icate be executed physician and s the burial-transit		d											
	certificate be executed ding physician and se as the burial-transit	Medical	IF FEMALE:								1			
ROX	0 2 2		23b. Was decedent pregnant 1 Live birth 2	☐ Fetal de	eath 3 🗌	Ectopic pregn	nancy						te of deliv	ery Day Year
5	the at	Physician	1	me of deat	th 5□	Other (specif	fy)				.	IVIO	71111	Day Teal
7.	The law requires that the death certific tte has been signed by the attending p rage 2 should be detached for use as		Part II. Other significant conditions contributing to death but	not resultir	na in the un	derlvina caus	e aive	en in Part I.		23e. Dio	tobacco	use cont	ribute to t	he cause of deatb#
Records,	signe d be	d by	CHE. CRE on dilyny.		9	,g	- 9				Yes		3 ☐ Prol	
ဂ် ပ	w requires some signer should be	Completed								24a. Wa	e an	24h	Moro auto	opsy findings available
Ď	he lav e has	дш				<u> </u>				au	topsy formed?		prior to co death?	mpletion of cause of
_			25. Was case referred to medical					26 Place	of Dogth	1 Yes (Check only		10	1 □Yes	2□No
5	hysician: The la his certificate ha I director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient	2□ER	VOutpatient	3□ DOA	Othe	or.		ne 5□Re		6 □Oth	er (Sneci	fv)
סר	ding Ph h. After thi funeral	n: T	27. Manner of Death 28a. Date of Injury (Month, Day)	28	Bb. Time of Injury		Injury Work			8d. Describ				
Ö	ath. ar: Af be fur	atio	2 Accident investigation		,,			Yes 2□N	No					
UIVISION	r Atto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc.	/ - At home (Specify)	e, farm, stre	et, factory, of	fice		2		(Street a		er or Rur	al Route Number,
)	oital ours af													
	Hos 24 ho Fune stely f	Medical	29a. Certifier 1 Certifying Physician: To the best of check only one) 1 Medical Examiner: On the basis of earth one) 2 Medical Examiner: On the basis of earth one)	xamination	edge, death n and/or inv	estigation, in	my o	ne, date and pinion, dea	id place, a ath occurre	and due to the	e, date a	(s) and ma and place,	anner as s and due t	stated. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification in the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director direct	Mec	29b. Signature and title of certifier			29c. Lie	cense	e number			29d. D	ate signe	d (Month.	Day, Year)
	WIL		M. Kara	M	n.	m	Di) 66	16	6		41	4 /	08
'	W-15		30. Name and address of person who completed cause of dea	th (Item 23	3a) (Type, F		シビ	, 66				- 1	1	
			Mudusar Raza 400	o We	st		5+,	reet	1	=rede	-i21	c, m	D.	21701
N	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's	s Signatur	е	12								
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's	us ,	K.	bert	β							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08-02828 Thomas Saunders Please Type or Print in Black Indelible.Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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omas caamaci		- For State	or maryiar		ficate of	Death	•		,,,	Reg. 1	No.	40		020
Physicia		Registrar 1. Decedent's Name (First, Middle,La	st)						8.40	te of Death onth Da	av '	Year	3. Time of Dea	
edical Examin		Thomas	John	Saund	ers				Ap	rii 11, 200	g		0420 hrs	
and the		4a. Facility Name (if not institution, gi	ive street and num	iber)	4	b. City, Tow		cation of I	Death			nty of Deat		
		Prince George's Hospital				Cheverly	/					e Georg		
Funeral	\neg	5. Social Security Number 6. 5	Sex 7	'. Age (In yrs. last	birthday)	If Under 1	_	If Under 2 Hours	24Hrs. 8. E Min.	Date of Birth(N	/M/DD/Y	Forei	irthplace (State o ign	
Director		220-78-0849	₹ M 2 F	38	Yrs.	Months	Days	Hours		3/10/19	970	C	ountry Mary	Land
	-	Usual Residence of Decedent								S W 11			10d. Inside Ci	
any	Γ	10a. State 10b. County		10c. City, To	own or Locati	on							1 Yes 2	
nd show	۱	Maryland St. M	Mary's			Lexi	ingt	on P	ark					. 21 140
laryla	詙	10e. Street and Number				10f. Zip Co	de			10g.	Citizen of	f What Co	untry?	
the M a or 2 tified	Director	47436 South Ham	oton Driv	ve.			206	553					tates	
with ns 23	힐	11. Marital Status	12. Was Dece	edent Ever in U.S.	. 13. Wa	s Decedent	of Hispa	anic Origin	? (Specify	Yes or No-		Race - Ame Vhite, etc.	erican Indian, Bla	ıck,
hours after death with the Maryland natural", or items 23a or 28a-f show any Examiner must be notified at once.	Funeral	1 X Never Married 2 Marrie	ed Armed For	2 X No					0010100	,, 0,0.,			1	l
after	Ď.		ed If Yes, Give Year or Dates:		1	Yes 2X						of Business		
5-0036 led within 72 hours after Hygiene. other than "natural", the M diesl Examiner.	ğ[15. Decedent's Education (Specify			16a. Deceden during m	t's Usual Oc ost of workin	cupatio g life. [on (Give kir DO NOT us	na of work a se retired)	ione	ob. Kiria u	ii Dusiliess	s/industry	1
6 72 h an "r ical E	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)			T.T	.1.			E.	and T	ndustry	ļ
withit iene.	Ĕ.	12	-4\		Kesta	urant	WOI	Ker 8 Mother's	Name (Firs	t, Middle, Mai			ndustry	
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica		17. Father's Name (First, Middle, La					- ["					,		
12'd be d be larke larke	o Be	Joseph Clement 19a. Informant's Name/Relationship	(Type Print)		19b. Mailin	Address	Street	and Numb	er or Rural	e Saun Route Numbe	er, City or	Town, Sta	ate, Zip Code)	
MD 21215-003 dd 2 should be filed within the and Mental Hygiene. m 27 is marked other the aumatic event, the M-d				ator									MD 206	53
y, MD 21215-0036 and 2 should be filed within 72 feath and Mental Hygiene. trem 27 is marked other than "traumatic event, the Medical 1		Ramona K. Gwanya 20a. Method of Disposition	nya / SI	20b. Pl	ace of Dispos	ition (Name	of cem	etery,	Dat	te 2	20c. Locat	tion - City	or Town, State	
nore, MD 2121: ages 1 and 2 should be fi nt of Health and Mental 1 it: If item 27 is marked other traumatic event,		1 X Burial 2 Cremation		om State	ematory or ot				0//10	/0000	a .	T		rr1 and
timor. Pages tment of rtant: If		4 Donation 5 Other Spec		Mt.	Zion	Cemet	ery	of Facility	04/19	/2008 <u> </u>	St.	Inigo	es, Mar Home, P.	y I and
Baltimore, MC permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traums		21. Signature of Funeral Service Lic	Min	0 x01501									10 20650	
		Shawn Ayleswort 23a. Part I. Enter the disease, or co	mplications that ca	MO1521 aused the death.	Do not enter	the mode of	dying, s	such as ca	rdiac or res	piratory arrest	t, shock, o	or heart	Approximat	te Interval
Physician ical		failure. List only one cause on	each line.										Between O	
kaminer	1	Immediate Cause (Final disease or condition resulting in death)		consequence of)		Onest								
		Sequentially list conditions,	b.											
	Je	if any, leading to immediate	Due to (or as a	consequence of)	:									
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876 tifica ing ph	Ž	23b. Was decedent pregnant in the past 12 months?	1 Live b	pirth	2 🔲 F	etal death	3	Ectopic	pregnancy		Mor	nth	Day	Year
Box 687 The death certifice the attending properties as the for use as the form of the second of th	Physician/			nant at time of dea	ath 5 C	ther (Specif	(y)				Ť			1
Bo e dea the a	hys		9 Unkil	own o death but not re	aultian in the	. undoduina s	20100 0	iven in Pa	d I	23e. Did tob	acco use	contribute	e to the cause of	death?
ires that the dates that the dates by the da	β	Part II. Other significant condition	ns contributing to	o death but not re	salang in the	underlying c	ause y	ivoir iii i c					Probably 4 [
S, T	Pa								- 11	24a. Was ar	1	24b. Were	e autopsy finding	s available
ords, w requir	Completed									autops perforn	у	prior death	to completion of	cause of
ecc he la ate ha	E									1 ✓ Yes 2		1 🗸		No
n: T	a	25. Was case referred to medical				20			(Check only					
Vita ystcia his ce direc	To B	examiner? 1 ✓ Yes 2 No			ER/Outpatie			Other ₄	Nursing H		Residence		ther:	
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific its after death. **Al Director** After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the standing of the content of the detached for use as the content of the content of the content of the standing of the content		27. Manner of Death	28a. Date (Monti	of Injury h Day Year) 2008	28b. Time of	Injury 28		ry at Work	. Isu	d. Describe ho bject shot		occurred		
ion tendii eath. lor: /	흝	1 Natural 5 Pendir 2 Accident Investi	gation		2345 hrs			Yes 2 ✔	No	•				
IVISIOR or Attence after death Director:	≝	3 Suicide 6 Could	280 Plan	ce of Injury - At ho	ome, farm, str	eet, factory,	office b	ouilding, et		or Town St	ate)		r Rural Route Nu	mber, City
Dital ours at Illed	Certification	4 V Homicide determ	1-1-17	Parking Lo						618 Liberty		_		
Hosp 24 hc Fun etely	i	Chican any	sician: To the be	st of my knowled	ge, death occ	urred at the	time, da	ate and pla	ace, and due	e to the cause	e(s) and m	anner as	stated. to the cause(s)	
Divis To the Hospital or At within 24 hours after To the Funcral Direc completely filled in by	Medical		and manner	of examination a stated.	nd/or investig								(Month, Day, Yea	ar)
- > - 0	Σ	29b. Signature and title of certifier	1 11	Ro		290.	O.C.	se number				11, 2008		T/
		Mhun Dr	and 4	112			U.U.	141. ⊆.			, will 1	., 2000		
		30. Name and address of person v				Penn Str	00t 5	Raltimor	o MD 21	201				
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S Regis	tate	• (100.7)	6 2008	Garage Signal	B.	boots	,							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Dortha Mae Spratt April 16, 2008 /Medical 6:04 a.m. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min. 1 □ M 2 🗓 F 82 **Director** 107-18-3284 10/23/1925 0klahoma Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10d. Inside City Limits er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes XX No Maryland St. Mary's Tall Timbers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44316 Tall Timbers Road death v 20690 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify. ģ White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12 Logistics Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Loranzy Jennings Lowe Ruby G. Gaddy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 19275 Piney Point Road, Valley Lee, MD 20692 Janis Lee Adams / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park 4-20-2008 Fairfax, Virginia 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGRETIUR HAMPIT /Medical Due to (or as a consequence of): Examiner HYPARTRN SIUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi NYPARCHULASTAROCAMIA and Due to (or as a consequence of): physician certificate be Physician/Medical DIABRIRS MACLITU the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes 21**7** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatore and tive of certifier

State

Box 68760,

Ö

م

Division or Vital Records,

John L. Bennett, 31. Date filed (Month Year) 32 D 0019052

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett KID

M.D., 23263 By the Mill Road, California, MD 20619



Registrar

			For State Registrar	State of M	aryland /	-		f Health and of Death	Mental H	ygiene Reg. No.	m m 12 a	3 13276
	Physic /Medi	_	1. Decedent's Name (First, Middle Robert Le	_{e, Last)} ewis Shankle	e, Jr.				2. Date of D Month April		2008 Year	3. Time of Death 10:20 AMM
	Exami		4a. Facility Name (If not institution 315 Queen St	reet			Fre	n, or Location of Deat derick		I	County of Dea	ck
	Funeral Director		5. Social Security Number 218-80-7236 Usual Residence of Decedent	6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. last	birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min.		ay, Year)		thplace (State or Foreign ountry) ryland
	e Maryland ta-f show tifled at	ctor	10a. State 10b. County	erick	10c. City, T	own or Loc ederi						10d. Inside City Limits 1 X Yes 2 □ No
	eath with the Marylar ns 23a or 28a-f show must be notifled at	Funeral Director	10e. Street and Number 315 Queen St				10f. Zip Cod 21	^{de} 701		U.	sen of What C	
980	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notifled at	by	11. Marital Status 1 Never Married XX Mari 3 Widowed 4 Divorced	If Yes, Give			Vas Decedent fYes, specify ☐YesXX☐	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or Note Rican, etc.)	10-	14. Race - Am Black, Whi Specify: W	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.	Be Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)		(Give I life. E		ccupation one during most of wo stired) r/Medic	rking		nd of Business e Servi	
land 2	uld be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (<i>First, Middle,</i> Robert	Last) Lewis Shankl	le, Sr.			18. Mother's Na Bett	me (First, Midd y Louis		,	
, Mar	and 2 sho salth and I 27 Is me er traums		19a. Informant's Name/Relations Diana L. Shank			27 Mc	ountain	reet and Number or R Road, Thu				Zip Code)
imore	Pages 1 ament of He ant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		nt Moun	t 01i		metery Apr		8002		
Ball	permit Depart Import any in		21. Signature of Faneral Service	Licensee	M0025	5 K	Name and A Ceeney 06 Eas	ddress of Facility and Basfor t Church S	d PA Fu St., Fre	nera deri	l Home ck, MD	21701
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each Arter	line.	onot ente	er the mode of		c or respiratory	arrest,	,	Approximate Interval Between Onset and Death Years
成	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	s a consequen					-	_	
8760,	certificate be executed ding physician and ise as the burial-transit	ical Examiner	Cause Disease or injury that initiated events resulting in death) Last	c	s a consequen	ice of):						
O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2 □ Fetal de at time of deatl	ath 3	Ectopic pregn				23d. Date of do Month	elivery Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditi Deep Venous T	-	but not resultin	ng in the un	nderlying cause	e given in Part I.				to the cause of death? Probably 4 ☐Unknown
al Rec	The law ate has b page 2 sh	Completed							24a. Wa au pe 1∐ Yes	opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of s 2XXIIo
r Vit	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes XXNo	Hospital: 1 ☐ Inpat	ient 2□ER	/Outpatien	t 3 DOA	26. Place of De Other: 4 ☐ Nursing	ath <i>(Check onl</i>) Home 5 X Re		6 □Other (Sp	ecify)
Division or Vital	d ing After fune		27. Manner of Death 11 Natural 5 Pendir 2 Accident investi	gation	jury 28 ay Year)	Bb. Time of Injury		Injury at Work? 1 Yes 2 No	28d. Describ			
Divis	Hospital or Atten 4 hours after death Funeral Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Flace of it building, 6	etc. (Specify)				City or 7	own, State	e)	Rural Route Number,
	Hospi 4 hour Funer tely fill	ical (29a. Certifier (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	t of my knowle of examination	edge, death n and/or inv	occurred at t vestigation, in	ne time, date and plac my opinion, death occ	e, and due to the	e, date and) and manner a d place, and di	as stated. ue to the cause(s)

nd manner as stated. lace, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

April 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 2 3 2008

Julio Menocal, M.D., 110 Baughmans Lane, Suite 140, Frederick, MD 21702 31. Date filed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

land ow at		10a. State	10b. County		10c. City, Tow	n or Loca	ation					10d. Inside City Limits
Mary f sh ied a	io	Maryland	Prince (loorgo!c	T n	nham						1 ∑Yes 2 No
the 28a notif	Director	10e. Street and Nu		seoige s	La.	шаш	10f. Zip Code			10g. Cit	izen of What Co	untry?
n 72 hours after death with the Maryla "natural", or items 23a or 28a-f shov adical Examiner must be notified at		9885 Gr	eenbelt F	Road			20706			IIn	ited Sta	itas
ms 2	Funeral	11. Marital Status		12. Was Decedent I	Ever in U.S.	13. W	as Decedent of H	lispanic Origin? (Sr	pecify Yes or No		14. Race - Ame	rican Indian,
r iter			ied 2X Married	Armed Forces?	No			an, Mexican, Puèri	o Rican, etc.)		Black, White	
al", o	by	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Dates:		11	☐ Yes 2 No	Specify:			Specify: B]	Lack
72 ho natur lical	ted	(Spec	15. Decedent's Ed		16a	. Decede	ent's Usual Occup	ation during most of wor	kina	16b. Ki	ind of Business/	Industry
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ygier ygier rer th	Š			5 years	F	<u>inan</u>	cial Sta	tistics			Governme	ent
be fill tal H d oth	å		(First, Middle, Last)					18. Mother's Nam	(,	,	Surname)	
ould I Mer narke	은		• Southal		1.00				ie Jones			
12 sh hand ris m rraum			ame/Relationship () Crum - D			-		and Number or Au Drive M:				
1 and Healt sm 2	ш	20a. Method of Disp					tion (Name of	DIIVE II.	Date		ocation - City or	
tiges if ite		1∭∑ Burial 2	☐Cremation 3 ☐	Removal from State	cemete	ry, crema	atory or other plac	i i			•	
t. Pa rtmer rtant:			5 Other (Specify		Harmon		em. Park				Landover	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	uneral Servide Lider	J. C. 23	11			ss of Facility St				
		23a Parti Enter t	the disease or com	plications that caused	the death Do	_					gron, be	Approximate
		shock, or hea	art failure. List only	one cause on each l	le.		4	7		arrest,	. 3	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	rniai n	а	1		er	Wise	ay			ylen
Examiner			- 6	Due to (or as	a msequence	of):						0
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leath certific attending p	N/N	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome 1 □ Live birth		. a□r	etapla presenta				23d. Date of del	ivery
deat le atte	icia	in the past 12 1 ☐ Yes 2 [No	4☐Pregnant at			Ectopic pregnancy Other <i>(specify)</i> _	·			Month	Day Year
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iw requires that been signed k should be deta		Part II. Other signi	1	ontributing to death be		^	terlying cause giv	en in Part I.				the cause of death?
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tendi eath.	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be					Yes 2 ☐ No				
frer direct	Certification	4 ☐ Homicide	determined	28e. Place of inju building, et	ury - At home, fa c. <i>(Specify)</i>	arm, stree	et, factory, office		28f. Location (City or To	(Street an wn, State	nd Number or Ru e)	ıral Route Number,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director,	Medical	29a. Certifier (Check only one)		ysician: To the best on niner: On the basis of and manner sta	f examination a							
ithin (Mec	29b. Signature and	I title of certifier	and mariner sta) ,		29c. Licens	e number		29d. Da	te signed (Mont	h. Dav. Year)
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Physic /Med		MICHAEL K	•	TERRY					MARCH	31 2008		8:30	РМ
Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. Cit	, Town, or	Location of	f Death		4c. County o			
		GLADYS SPELLMA	N SPECIALI	TY N.H.	HY	ATTSV				PRINCE	GEC	RGE'	S
Funeral Director		577-76-7149	ex 7. Age	(In yrs. last birthday		er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, APRIL 3	^{Year)} 1956 V	Count	ace (State try) NGTO	or Foreign
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10	nside	City Limits
ne Maryla 8a-f eho	octor	MD PRINCE	GEORGE'S	SEAT PLE	ASAN							1 🔏 Ye	s 2 No
or 2	100	10e. Street and Number				ip Code			11	Og. Citizen of WI	at Coun	try?	
eth v	<u>62</u>	512 62nd PLACE	#B			20743				USA			
ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If I tem 27 is marked other than "naturel", or Items 23a or 28a-f ehow or other traumatic event, the Moulcal Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:			edent of Hi ecify Cuba		gin? (Spec , Puerto R	cify Yes or No- tican, etc.)	14. Race Black Specify:	White, e	etc.	
ad within 72 hours aft giene. er than "naturel", or in the Moulcal Exami	Completed by	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5	(Give	dent's Us kind of v DO NOT	ual Occupa ork done o use retired	ation during most	of workin	g	16b. Kind of Bus	ness/Ind	lustry	
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and 2 should salth and Men n 27 is marke	-	19a. Informant's Name/Relationship (YVONNE TERRY/WIF								City or Town, S ANT, MAI			.0743
t Height		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (N	ame of	e)	Da	ate	20c. Location - C	ity or To	wn, State	
Pages nent of int: If it iry or o		1 Purial 2 Cremation 3 4 Donation 5 Other (Special		HARMON			1	4/7/	2008	LANDOVE	R,MAI	RYLAN	D
permit. Pages 1 and Department of Health Important: If tem 27 eny Injury or other troone.		21. Signature of Funeral Service Lice			2. N <i>a</i> me	and Addres	s of Facility	y J.	B. JEN	KINS FUI ER,MARYI	VERAI		E
Physician /Medical		23a. Part1. Enter the dis set, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ASPIR	the death. Do not ene. ATION PNEU			g, such as o	cardiac or	respiratory arre	est,		Approxim Interval B Onset and	etween
Examiner purpose transit	Examiner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	з солведналов эт):									-
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The law requires that the death certificate ate has been signed by the attending phy page 2 should be deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic ⊒ Other (pregnancy specify)				23d. Date Mon		ry Day	Year
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Hospital or Attending Physician: 14 hours efter death. Funeral Director: After this certificat tely filled in by the funeral director, p	Certification;	3 Suicide 6 Could not be 4 Homicide determined		iry - At home, farm, s c. (Specify)	reet, fact	ory, office		2	8f. Location (St City or Town	reet and Numbe i, State)	or Aura	l Route Nu	ımber,
To the Hospital or Attentwithin 24 hours effer dealt To the Funeral Director: completely filled in by the	Medicai (29a. Certifier 1∑ Certifying Pl (Check only 2 Medical Exa	nysician: To the best on miner: On the basis of and manner sta	examination and/or is	th occurrenvestigation	ed at the tin	ne, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, d	ause(s) and man ate and place, a	ner as st id due to	ated. the cause	e(s)
To the within 2 To the complet	W	29b. Signature and title of certifier	ME T	10	2	9c. Licensi DO	number 02602	4	2	9d. Date signed APRIL	(Month, 1)
- (5)		30. Name and address of person who LESTER MILES M.		eath (Item 23a) (Type		.E. W.	ASHIN	GTON .	DC 200)17			
St Regist	ate trar	31. Date filed (Month, Day, Year) ADD 0 3 2008		ar's Signature	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** KOBERT THOMAS 13:02 APRIL 2008 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Yea 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 46 221-60-1698 March Director 12 Usuai Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at New Castla Wilmington DE 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? U.S.A 5500 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Affiled Forces:

| Syes 2 | No
| Yes, Give
| Year or Dates: | 980 - 1982 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heating & AirConditions Repair mon 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SUMMEN Zonamer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Zonames 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State April 9,2008 Wilmington, PE Family Cormation Service 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses lasteh er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failere. I Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MULTILOBAR PNENMONIA 2 days /Medical Due to (or as a consequence of): Examiner ALLIE LIVER FAILURE 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit HERATITIS C CIRNHOSIS Due to (or as a consequence of): Box 68760. physician Physician/Medical attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f or Vital Records, P.O. 9 Unknown 9 ☐ Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA al or Attending Physis after death. ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Attending 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) April 06, 2008 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERONIQUE NUSSENBLATT THE JUHNS HORIGING HOSPITAL, 600 North woife Street Balkmore, MD 21287

State Registrar 31. Date filed (Month, Day, Year)

9 2008

			1- State of Maryland / Department / Department	artment of Health and N <i>rtificate of Death</i>			
	No ve		Hegistrar 1. Decedent's Name (First, Middle, Last)	Timouto of Bouin	2. Date of Death	No. 2008	3. Time of Death
	Physici /Medic		James William Tippett		April 16,	^{Day} 2008 Year	8:45 P M
	Examin		4a. Facility Name (If not institution, give street and number) 45389 Tippett Road	4b. City, Town, or Location of Death Hollywood		4c. County of Death	Mary's
i i	Funeral Director		5. Social Security Number 578-34-2313 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye December 6,	9. Birthp Coun 1929 Distri	lace (State or Foreign try) ct of Columbia
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		11	0d. Inside City Limits
	Maryl t-f sho fled a	tor	Maryland St. Mary's	Hollywood			1 ☐ Yes 2 🖾 No
	th with the 23a or 28e ist be noti	Funeral Director	10e. Street and Number 45389 Tippett Road	10f. Zip Code 20636	10g.	Citizen of What Coun	try?
036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2K Married 1 Yes 2K No	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2ᡌ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho lene. than "natu he Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) t Manager	king I	S. Postal	
land 2	uld be filed whental Hygierked other tice event, the	To Be Co	17. Father's Name (First, Middle, Last) George Tabor Tippett	den Surname) Y			
Jary	s 1 and 2 should be f Health and Menta tem 27 is marked other traumatic ev		1,500	ing Address <i>(Street and Number or Ru</i> 9 Tippett Road I	iral Route Number, Ci		Code)
	of Health item 27		20a. Method of Disposition 20b. Place of Dispo	osition (Name of		. Location - City or To	wn, State
MO M	0.0	1	1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Catholic Apri Cemetery	1 21, 2008 Hol	lywood, Mary	land
Baltimore,	permit. Page Department of Important: If any injury or once.			2. Name and Address of Facility Mattingley-Gardiner P.O. Box 270 Leona:		P.A. 0650	
			23a. Part I. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
y.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to Irras a consequence of:	Preuminia ascular accide			
	Examiner		Cerebral Va	uscular accid	leut		
	pe sit	iner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
,	icate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last C				
68760,	ate be in ysicial	dical	d				
			IF FEMALE: 23c. If yes, outcome pf pregnancy				
.O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death? ably 4 ∐Unknown
Il Records,	The ate h page	Completed			24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of 2 ☐ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	ath (Check only one)		
o	ing After une	ion: To	27. Manner of Death 1 SAnatural 5 Pending (Month, Day Year) Injury	4 Nursing H	28d. Describe how i	e 6 □Other (Specifinjury occurred	y)
Division	4tten deatl ctor: y the	Certification:	2		28f. Location (Stree City or Town, S	t and Number or Rura State)	I Route Number,
_	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea continuous and manner stated.				
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number 400557		Date signed (Month, 4 - 17-02	0,
			30. Name and address of person who completed cause of death (Item 23a) (Type Jennifer Schmidt, M.D. 40900 Merch			dtown. MD	20650
	Sta	ite.	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
7.	Registi	_	APR 1 8 200x				

Amended Item 23a Part I a per Physician, 04/09/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) Date of Death
 Month Day **Physician** Linda Kay Wilhelm 2008 6:58 A April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore County Manchester 3730 Rockdale Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 12, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F 214-46-0748 60 Yrs. 1947 Mary Land Director Usual Residence of Decedent the Maryland r 28a-f show notified et 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County Manchester 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? with 1 o e 3730 Rockdale Road 21102 United States ns 23e c must by death v Funeral rai", or items ? 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or item yor other traumatte event, the Medical Examiner by or other traumatte event, the Medical Examiner. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (maiden name Be Paul Thomas Cooper Caroline Marquarite unknown) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Steven D. Wilhelm - husband 3730 Rockdale Road Manchester, Maryland 21102 permit. Pages 1 and:
Department of Health
Important: If Item 27:
any injury or other tr.
once, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20a. Method of Disposition Date 20c. Location - City or Town, State April 8, 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service License Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Terminal Aspiration disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): 68760. attending physician Box (IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 4☐Pregnant at time of death Month Day Vear signed by the at d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No should 3 Probably 4 Unknown been DEPENDENCE NARCOTIC 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No The certificate Vital 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 No 1 Yes Certification: To ö this 6 ☐Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Division Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOSTER, MO. 6565 N. CHARLES HZO3 BALT MO ZIZOG FAUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Glown & Sports DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2008 April 7, 9:55 a M Rachel Virginia Wantz 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Frederick North Hampton Manor 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 3, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 X F 80 Maryland 216-22-9526 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Emmitsburg Maryland Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21727 USA 10354 Harney Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 🗷 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Shoe Making 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles L. Wantz, Sr. Georgina Ridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Eckenrode, son 5135 Haywood Ruffin Road, St. Cloud, FL 34771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Elias Lutheran Cem. 4/11/2008 Emmitsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home R. 210 W. Main Street, Emmitsburg, MD 21727 inter 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Due to (or as a consequence of): FAILURE TO Due to for as a consequence off Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a Was an

Physician /Medical **Examiner**

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Pages 1

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Sem 27 Is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-trar physician as the l for page 2 s director,

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

WJL

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy performed? 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D00 47951

TOLL HOUSE AVE, FREDERICE, My 21701

4-07-2008

State Registrar

DHMH 17 Rev 1/2001

doarde

814

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAZMI, MM

A.

		1	For State Registrar		State	of Mary	land / Dep <i>Ce</i>	artmen <i>rtificat</i>			and M	ental Hy	giene Reg. No.	1 U U (3	13277	
			Decedent's Name (First	t, Middle, Last)							2. Date of De Month	ath Day	Yea	25	3. Time of Death	
	Physicia /Medic		Vernon	Royal	Walter									008	21	7:30a ^M	
	Examin	ner 4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death					County of D			
				gview Nursing Home						er If Under:	24 Hrs	C Data of Bi	46-		rrc		
	Funeral		5. Social Security Number 217–36–4658		x 3_M 2 □ F	7. Age (In	yrs. last birthday Yrs.	If Under Months		Hours	Min.	8. Date of Bir (Month, Da	ıy, Ye <i>ar)</i>		Coun	ace (State or Foreign try)	
	Director		Usual Residence of Dece									Aug. 1	, 192	Z 1	D.		
	yland			County			c. City, Town or L								10	Od. Inside City Limits	
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7	lled v tygies ther t		17. Father's Name (First,	Middle Last			Iar	mer		18 Mothe	r's Name	(First, Middle		arming			
anc	d be fundal H	Be C	Leonard Wa									eintzm		oumanno)			
2	Shoule nd Me mark mark	ဥ	19a. Informant's Name/R	elationship (T	ypa, Print)		19b. Mail	ing Address	(Street a	and Numbe	or or Rura	l Route Numb	er, City o	r Town, Stat	e, Zip	Code)	
Ž	alth al		Gladys Bo	osley W	alter,	wife	1420	9 Lon	gnec	ker R	load,	Reist	ersto	own, M	d.	21136	
Baltimore,	Pages 1 avenue of Healent of Heal		Gladys Bosley Walter, wife 14209 Longnecker Road, Reisterstown, Md 20a. Method of Disposition 1 Selection														
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<u> </u>	8255		Mande		Senn						, Ha	mpstea	d, Mo	d. 210	74		
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Вох	eath certifi attending for use es	lan/l	23b. Was decedent pregr in the past 12 month	nant		birth 2	Fetal death 3	□Ectopic p						23d. Date of Month	delive	ny Day Year	
0	the a	ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown		4∐Preg 9□Unki	nant at time	e ol death 5	Other (sp	oecify)								
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<u>></u>	lysici iis cei direc	To B	examiner? 1 ☐ Yes 2 ØNo		Hospital: 1 [] Inpatient	2 ER/Outpatie	ent 3 DC	OA Othe	9r: 4 KNL	irsing Hor	me 5□Res	idence	6 Other (Specify)	
0 0	Attending Physicien: or death. ector: After this certification in the funeral director, it		27. Manner of Death	Pending	28a. Date (Mo	of Injury oth, Day Ye	28b. Time (ar) Injury	of 2	28c. Injun	at k?	1	28d. Describe	how inju	ry occurred			
Sio	eath. or: A the fu	cati	2 Accident	investigation Could not be				М	1 🗆 '	Yes 2							
Division of Vital Records,	i or Ati efter d Direct I in by	Certification:	4 Homicide	determined	200. Plac	e of Injury ding, etc. (5	- At home, larm, s Specify)	treet, factor	y, office		1		(Street and Number or Rural Route Number, own, State)				
J	To the Hospital or Attending Physicien: The law requires the within 24 hours effer death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de		29a. Certifier	Certifying Phy	/sician: To th	ne best of m	ıy knowledge, dea	th occurred	at the tim	ne, date an	id place, a	and due to the	cause(s	and manne	r as si	ated.	
	n 24 h	edicai	(Check only 2 🗍 🖡	Medical Exam	iner: On the	basis of ex nner stated	amination and/or i	nvestigation	n, in my o	pinion, dea	ith occurr	ed at the time	, date and	d place, and	due to	the cause(s)	
	To the within 2 To the complet	ĕ	29b. Signature and title o	of certifier				29	c. License	number			29d. Da	te signed (M	lonth.	Day, Year)	
)	WIL		· Cac.	Jan	en,	u-			D/	290	/		H	7/0	5		
	3		30. Name and address of Deogracias V	r TAUST	2 4 8	ise of death), 4[[[L.Bcole		le Ro	L, HA	MPS	tead.	Md	2107	4		
	Sta Registi		31. Date filed (Month, Da	PR 0.8	2008	Registrar's					•						

Physician

/Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

Examiner

Certification: To Be Completed by Physician/Medical

Medical

31. Date filed (Moath, Day, Year)

2008

	Pleas				Indelible Ink.				_	le.	
For State Registrar		State of	Maryland		partment of F ertificate of		vientai H	ygiene Reg. No	0.0	ΩΩ	13278
1. Decedent's Name	e (First, Middle,	Last)					2. Date of D	Death Da	v	Year	3. Time of Death
William	Edward	Winter	s				April			1001	10:06 p ^M .m
4a. Facility Name (I	f not institution, g	give street and num	ber)		4b. City, Town, o	r Location of Death		40.	County o	f Death	
26150 Inc					Mechanio				. Ma	ry's	
Social Security N	lumber 6	.Sex 10X1 M 2 □ F	7. Age (In yrs. la	a <i>st birthd</i> Yrs	Months Dave	If Under 24 Hrs. Hours Min.		Day, Year)		Birthpla Country	ice (State or Foreign
218-38-69			67	118	•		04/28/	1940	l M	lary1a	and
Usual Residence of 10a. State	10b. County		10c. City	, Town or	Location					100	d. Inside City Limits
Maryland	St. Mai	cy t c	Mooh	ania	sville						1 ☐ Yes 2 📉 No
10e. Street and Nu	L	.y s	Hech	anic	10f. Zip Code			10a, Cit	izen of W	hat Countr	v?
		oo Dadaa									
26150 Inc	iependen		dent Ever in U.S	3. 1	20659 13. Was Decedent of H	lispanic Origin? (Sp	pecify Yes or N			tates - America	
	ied 2 🕅 Married	Armed For	ces?		 Was Decedent of H If Yes, specify Cubi 		Rican, etc.)		Black	, White, et	tc.
3 Widowed		If Yes, Give Year or Da	9	ļ	1 ☐ Yes 2 🖾 No	Specify:			Specify:	B1ac	ck
	15. Decedent's	Education			ecedent's Usual Occup			16b. K	ind of Bus	iness/Indu	
(Spec	, , ,	grade completed) College (1-	4or 5+)	(G lif	ive kind of work done e. DO NOT use retire	auring most of work d)	king				
9		College (1		Labo	orer			Con	stru	ction	<u>. </u>
17. Father's Name	(First, Middle, La	ast)				18. Mother's Nam	ne (First, Midd	lle, Maider	Surname	e)	
Joseph Al	Lexander	Winters				Elizabet	h Spea	rs			
19a. Informant's Na	ame/Relationship	(Type. Print)		19b. M	ailing Address (Street	_	_		or Town, S	State, Zip (Code)
Alice Wir	nters/Wi	fe		2615	0 Independ	dence Dri	ve, Me	chani	csvi	11e,	MD 20659
20a. Method of Disp			0.00	ace of Di	sposition (Name of crematory or other place	ce)	Date	20c. L	ocation - (City or Tow	n, State
	□ Cremation 3 □ Other (Specific Specific Spe	□Removal from S ecify)	tate		Memoria1	i	9/2008	Leon	ardt	own.	Maryland
21. Signature of Fu	neral Service Li	censee 4		7	22. Name and Addre	on of Facility					e, P.A.
Kyle S	S. Simon	s M0120	16	3	22955 Hol						20650
23a. Part1. Enter t	the disease, or co	omplications that ca	used the death	. Do not	enter the mode of dyin				COWII		Approximate
shock, or hea		nly one cause on ea	ich line.		-	1 1	11	0	1		Interval Between Onset and Death
disease or condition resulting in death)	on	_a. / 1/	endo	De	Whice of	andi)	Vares	Van	Cer	1 Aug	
		Due to (or as a consequ	ence of):							
Sequentially list co	onditions,	b	or as a consequ	ence of):							
if any, leading to in cause. Enter Unde Cause (Disease or	erlying	200.00	, ao a oo,100qa	01100 017.							
that initiated events resulting in death)	S	c	or as a consequ	ence of):							
		540 10 (,	01100 017.							
		d								-	
IF FEMALE:		000 16 100 014									
23b. Was deceden in the past 12			rth 2 ☐ Fetal	death	3 ☐ Ectopic pregnanc	y			23d. Date Mon	of deliver	y Day Year
1 ☐ Yes 2 [□No	4□Pregna 9□Unkno	ant at time of de wn	eath	5 Other (specify)			-	141011		/
		e contribution to 1-	ath hut not reco	Iting is 15	o underlying course ="	on in Part I	22- 0	d tobacca	1100 00=4-1	hute te #	a cause of death?
ran II. Otner signi	meant condition	s continuing to de	au Dul noi resu	iding in th	e underlying cause giv	en in Part I.			_		cause of death?
							1[Yes 2	!□ No	3	bly 4 Onknown
							24a. Wa	as an topsy	24b. W	ere autop	sy findings available
								rformed?	d d	eath?	pletion of cause of 2.12 No
25. Was case refer	rred to medical					26. Place of Dea					A
examiner? 1 Yes 2 □	No	Hospital: 1 🔲 II	npatient 2 □ l	ER/Outpa	atient 3 DOA Oth				6 □Othe	r (Specify))
27. Manner of Deat		28a. Date o	of Injury	28b. Tim	ne of 28c. Inju		28d. Describ				
1 Natural 2 ☐ Accident	5 ☐ Pending investiga		h, Day Year)	Inju		rk? Yes 2 □ No					
3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad Zoe. Flace	of injury - At ho	me, farm	, street, factory, office					er or Rural	Route Number,
→ ☐ momicide		Dulidir	ig, etc. (Specify	')			City or 1	Town, Stat	e)		
29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the xaminer: On the ba	isis of examinat	wledge, d	leath occurred at the ti or investigation, in my	me, date and place opinion, death occu	and due to to urred at the time	he cause(s ne, date ar	s) and mai	nner as sta ind due to	ated. the cause(s)
29b. Signature and	d title of certifie	,			29c. Licens	se number		29d. Da	ate signed	(Month, E	Day, Year)
	211.	mt	Cun			14285				1-08	
30. Name and add	ress of person w	ho completed cause	e of death (Item	23a) (Ty	rpe, Print)						
William	D. Boyd	II. M.D.	2536	Po	int Lookout	Road. I.	eonard	town.	MD	2065	.0

DHMH 17 Rev 1/2001

Registrar

			For State Registrer	State	of Marylan		rtment of H tificate of L			jiene eg. No.	08	13279	
	Physici	an	Decedent's Name (First, Midd STDNEY HE	ile, Last) RBERT WINI)ON				2. Date of Dea Month	Day	Year	3. Time of Death 1:32 P M	
	/Medic Examin	-	4a. Facility Name (If not institution 2026 Harkins	on, give street and n			4b. City, Town, or Pylesvi	April	4c. County	15 2008 4c. County of Death Harford			
	Funeral Director		5. Social Security Number 236-52-4633	6. Sex 1 M 2 ☐ F	7. Age (in yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 1/21/1		9. Birthpi Count	lace (State or Foreign try) Virginia	
	D		Usual Residence of Decedent 10a. State 10b. Count	у		y, Town or Lo	cation		1,2.,,			Od. Inside City Limits	
136	e Mary	ctor	MD Harf	Pyles	ville				1 ☐ Yes 2 No				
	h with the	al Director							1	-	g. Citizen of What Country? USA		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or itema 23s or 28s-f show imatic event, the Mudical Examinar man be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 M Widowed 4 Divorce	rried Armed F	2 🗆 No	1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e		
Maryland 21215-0036	within 72 ho ane. than "natur	Completed		nt's Education est grade completed		16a. Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired Carpente	turing most of work)	ring	16b. Kind of Business/Industry Construction			
and 2	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name Thoracteristics of the state of the						e (First, Middle, y Sams	First, Middle, Maiden Sumame) Sams			
Mary	2 E 5 B	9	19a. Informant's Name/Relation				g Address (Street a					Code)	
Baltimore, N	m O		Emma Beall/Daughter 50 Campbell Court, Conowingo, mD 21918 20a. Method of Disposition 152 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 50 Campbell Court, Conowingo, mD 21918 20b. Place of Disposition (Name of cemetary, crematory or other place) St. Paul's Cemetery 4/20/2008 Pylesville, MD										
Balti	permit. Page Depertment of Important: if any injury or once.		21. Senatur of Funeral Service		relid	/ 22	. Name and Addres	s of Facility	_	-	-		
-	Physician // Medical Examiner and physician and physician and physician be prival-transit	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						cand	homy	orate	ry ture.	Interval Between Onset and Death Mark	
P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	clan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 ∏ Feta gnant at time of c nown	ıldeath 3 ⊑	Ectopic pregnancy Other (specify)				te of delive	ory Day Year	
rds, P	quires that en signed b ruld be deta	ed by Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown			/	
Vital Records,	: The law recate has becate has becate has becate has because 2 shown and the second s	Completed			1				24a. Was a autop: perfor 1 Yes	med?	prior to con death?	psy findings available inpletion of cause of 2 1 40	
VIII.	ysician s certifi director	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	26. Place of Deater: 4□ Nursing Ho	/		ner (Specify	v)	
Division of	ending Ph sath. or: After thi	Certification; T	E L Accident	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injun Worl		ursing Home 5 Describe how injury occurred No			,	
Ö	urs after dural Direct		4 Homelde	mined 286. Place	ding, etc. (Specia	(y) 	eet, factory, office		28f. Location (S City or Tow	n, State)			
	the Hosp thin 24 hou the Fune mpletely fi	Medical	(Check only 2 Medical one)		ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred at the tin vestigation, in my of	oinion, death occur	red at the time, o	ause(s) and ma date and place, 29d. Date signe	and due to	the cause(s)	
)	To voit	-	29b. Signature and title of certif	. Atten	ding		D	1644	4	Afri	216	HW 2008	
			30. Name an address of person	NAIRI	N.D -	600	Print) 2. S. At	wood!	Kd.P	selai	n.N	1021014	
	Sta Registi	ite · ar	APR 2 3		Registrar's Signa	eture	80						

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

2 3 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 5:15 AM April 3, Herbert E. Alexander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Hebrew Home of Greater Washington Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 21, 1927
Connecticut If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director 048-26-2291 Usual Residence of Decedent la or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYYes 2 No Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with "natural", or items 23a 6121 Montrose Road U.S.A. 20852 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No Army
If Yes, Give
Year or Dates:1946-1948 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor College permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Alexander ဥ Pearl Schube 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth B. Alexander - Son 18306 Watercraft Court Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gdns. 4/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licensee D^{22. Name and Address of Facility}
Danzansky-Goldberg Memorial Chapels, Inc.
21170 Rockville Pike Rockville, MD 20852 Donald 23a. Part1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatio **Physician** 10 mos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner ng physician and as the burial-trans Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐No 3☐ Probably 4☐Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' Vital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | → No မ 1 Inpatient 2 ER/Outpatient 3 DOA ō 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 ⊞Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 "Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Muleur fluidethis 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address, of person who completed cause of death (Item 23a) (Type, Print) Load Kockville, Md. 20852 Kundratus. D. 6121 Montrose 31. Date filed (Month, Day, Year) 3. Registrar's Signature State APR 0 9 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lora1 Τ. Agee April 7, 2008 6:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing Home Kensington Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Sex 14 M 2□F 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **Director** 223-38-2748 75 July 25, 1932 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be profited. 10a, State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo Prince George's Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5616 Gallatin Place 20781 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2∏ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No δ Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Financial Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Annie Banks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra E. Agee - Wife 5616 Gallatin Pl Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Maryland Vet's Cemt. Apr 15, 2008 4 Donation 5 Other (Specify) Cheltenham, MD nse 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Onset and Death Immediate Suse (Final Physician HTN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate occur. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed that initiated events inding physician and use as the burial-train resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KDUnknown Completed Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: /
filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064624 April 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandeep Sharma 743 Summer Walk Drive Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State APR 1 0 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 9:01 pM 05 2008 George W. Burroughs Apri1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hillhaven Nursing Home Adelphi Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F Vrs 98 578-05-3220 Director August 30, 1909 District of Columbia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. inside City Limits r 28a-f show notified at 10b. County 1 TYes 2 KINO Director Maryland | Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code pe r ns 23a must b 3210 Powder Mill Road 20783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural', or items dical Examiner mi 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite any or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Plumbing Contractor Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ James Ernest Burroughs Mary Elizabeth Scheyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Burroughs - Son 2209 Falling Creek Road, Silver Spring, Maryland 20904 item 2 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 图 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/09/2008 Fort Lincoln Crematory Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Imand udelive 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Multilobar Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Š signed by the period of the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Macular Degeneration 1 ☐ Yes 2 No 3 Probably 4 IUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Hypothyroidism page 2 s has autopsy perform certificate 1 Yes 2 No Dementia Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours auce To the Funeral Dir 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) HD April 8, 2008 D55559 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, #316, Greenbelt, MD Thomas E. Maslen, M.D., 22. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 09

To the l

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 09

howdhy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. gistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

29c. License number

CHOWDHURY, MD: 15216 DINO DRIVE; BURTONSVILLE, MD20866

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Mental Hygiene 2 - State 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gerald K. Bolden, Sr 04 07 2008 11:02p [™] /Medical 4a. Facility Name (If not institution, give street and number) Anne Arundel Prince George's 4b. City. Town, or Location of Death Examiner 3386 Yellow Springs South Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 XM 2 ☐ F 66 Yrs. 293-34-3541 Director 06/06/41 Piqua, Ohio Usual Residence of Decedent the Maryland 10b. CountAnne Arundel 10c. City, Town or Location Anne Arunde Prince Ceorge Laurel 10a. State 10d. Inside City Limits r itema 23a or 28a-f ehov unar must be notified at Md 1 XYes 2 No Director 10f. Zip Code 207-24-7 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with I Hygiene. 3386 Yellow Springs South USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1961 — K☐Yes 2☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 X Yes 2 ☐ No Specify: Specify: Black Ď 3 Widowed 4 Divorced "natural" or than "nature. Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Graphic Artist 2years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ages t and 2 should be fill not of Health and Mental Ht: If item 27 is marked otty or other traumatic even Be Betty Jean Bolden William Harris ဥ 19a. Informant's Name/Relationship (Type, Print) Ramona Bolden Romona Bolden W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3386 Yellow Springs S Laurel ,Md Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages t Depertment of H Importent: If ite eny injury or ot: 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 04/15/08 Brentwood, Maryland Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Snead Mortuary Service, P. A 1409 Fairlakes Pl Ste B Mitchellville, MD an Approximate 2072 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed a Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Interstitial Pulmonary Fibrosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ②Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2□No 1 TYes 2 🗆 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) ٩ 1 Yes 2 No After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 9 To the Hospital of within 24 hours af To the Funerel D completely filled in 29a. Certifier 🎦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Md D0055522 April 8, 2008 H abert Tuaco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard 1500 Forest Glen Road Silver Spring, Md 20910

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 09 2008

32 Registrar's Signature

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and Death	d Mental Hy	giene /	2008	13286	
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Maryland f show ed at	or	Usual Residence of Decedent		Oc. City, Town or L					1	10d. Inside City Limits 1 ☐ Yes 2 X No
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ininportant if them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		ace - Americ ack, White,	can Indian,
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	State	30. Name and ddress of person when the ddres	o completed cause of death AO ZHU 32. Degistrar's	GGO I	medical	l cester	Drive	> Rou	(cvile	e, mos 2083
Regi			2008	. K. A	hack					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02583 State of Maryland / Department of Health and Mental Hygiene Lowell Blackmon Certificate of Death 1- For State Registrar Amend#1 PerMFOPGC4-10-Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 1, 2008 1418 hrs Lowell Thomas Blackmon, Jr. Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly Prince Georges Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Washington Min. Months Hours Director Days 579-98-6480 06/29/1965 1 X M 2 F 42 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 \mathbf{m} Washington 28a-f show notified at once. death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 5054 Benning Road, S.E. 20019 U.S.A. 23a 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes Black hours after Yes, Give Year Yes 2 X No specify: Specify Divorced "natural" Examine þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 the Medical nt of Health and Mental Hygiene. nt: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 12th Carrier Private 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Lowell Thomas Blackmon, Sr. Emily Hill Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Blackmon - Mother 5054 Benning Road, S.E.; Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)

Ft. Lincoln Cemetery 1 X Burial 2 Cremation 3 Removal from State 04/05/2008 Brentwood, Maryland tment c tant: or oth Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services ature of Funeral Service Licenses 4594 Beech Road; Temple <u>Hills, Maryland</u> 20748 Approximate Interval r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease. Physician Between Onset and ailure. List only one cause on /Medical a. Pulmonary Thromboembolism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Deep Venous Thrombosis Sequentially list conditions, Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause Examine -(Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify)

The law requires that the death certificate be executed attending physician a Box 68760. ned by the a detached for o Division of Vital Records, P. has 2 sl certificate To the Hospital or Attending Physician: within 24 hours after death. After this Director:

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Completed

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Certification:

Medical

State

3

Suicide

Homicide 29a. Certifier

29b. Signature and title of certifie

Year 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other, examiner? Hospital: Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? Manner of Death 1 V Natural Yes 2 No Pending 2 Accident Investigation

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

To the Funeral Registrar

Pamela E. Southall, MD Assistant Medical Examiner 32. Registrar's Signatu

(Specify)

31. Date filed (Month, Day, Year) 2008

Could not be

determined

Youthall MI 30. Name and a draffs of person who completed cause of death (Item 23a)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

April 2, 2008

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State)

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2008 1:13 PM Greg Allen Belcher <u>April</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 107 Superior Court Cecil North East Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1**X** M 2□ F 465-31-5738 <u>Sept. 25, 1960 New Jersey</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits North East 1 ☐ Yes 2 🔯 No Maryland Cecil 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 107 Superior Court 21901 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 170 Yes 2 No Navy If Yes, Give Year or Dates: 1979-83 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√√ No Specify Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Belcher Emma Ethel Eck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma E. Belcher / Mother 107 Superior Court, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 8, 2008 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home rvice Li 127 South Main Street, North East, Maryland21901 Approximate
Interval Between
Onset and Death
UN Known rart1. Enter the disease, or complications that caused the seath. Lo not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nom to (or as consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of 0 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2[XNo Hospital: Other: 4 Nursing Home 5 Residence 3□ DOA 1 ☐ Yes 2 ER/Outpatient 1 Inpatient 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 🗌 Yes

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2192

/Medical Box 68760 P.O. Records, Division or Vital the Hospital or Attending

Examiner physician and s the burial-trans pe attending p for use as ģ signed t certificate Physician: this After in 24 hours after the function of the Funeral Director: After the function of

Physician

/Medical

Examiner

Funeral

Director

28a-f show

with the

5-0036

altimore, Maryland 2121

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should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or iter

t and 2 should be fill Health and Mental H tem 27 Is marked ott

Pages 1

permit.

Department of Health Important: If item 27 Is any Injury or other tra

Physician

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

traumatic event, the Medical

Director

Funeral

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Completed

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Physician/Medical

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Certification:

cal

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

29b. Signature and title of codifier

as

page 2

director

541VA State Registrar

To the

31. Date filed (Month, Day, Year) APR 0 8

5 Pending investigation

6 □ Could not be

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type,

•			for State	State	of Ma	aryland		artment of tificate or		ınd M	ental Hygi	21	108	13290
			Registrar 1. Decedent's Name (First, Middle	l aet)			Cei		Deam		2. Date of Death	g. No, 👇 🐫	700	3. Time of Death
	Physicia	an	The Book and the firm of the f		773	n Hair		D == ====			Month	Day	Year	M
-	/Medic		4a. Facility Name (If not institution			и патт	ISOII	4b. City, Town,	or Location of	f Death	April 1	4c. County		6:00 A [™]
1	Examin	er	Homewood At M		,									
	Europal	-	5. Social Security Number	6. Sex	-	e (In yrs. las	t birthday)	If Under 1 Yea	liamspo		8. Date of Birth		shing	lace (State or Foreign
	Funeral Director		215-14-1530	1 M 2□		89	Yrs.	Months Day	s Hours	Min.	(Month, Day, Oct. 29	Year)	Coun	aryland
			Usual Residence of Decedent								000. 25	,1010	na	<u>ryranu</u>
	yland		10a. State 10b. County			10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	a-fs	ctor	Maryland Was	hington				Hag	erstown	2				1 Yes 2 □ No
	h the	jre.	10e. Street and Number					10f. Zip Code			10	g. Citizen of	What Coun	itry?
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evar. incriust be notified at	Funeral Director	7 East Washing	ton St.	Apt	# 202		2	1740			U.	S.A.	
	dea	iner	11. Marital Status	12. Was D		Ever in U.S.		Was Decedent of f Yes, specify Cu	Hispanic Orig	jin? (Spe	cify Yes or No-	14. Ra	ce - Americ	
٥	or ite		1 ☐ Never Married 2 ☐ Marr	ied 1 □Ye	Give	No		☐Yes 2 ∑ N		, i deito i	ilicari, etc.)			
5-0036	ours	d by	3 ☑ Widowed 4 ☐ Divorced	Year	or Dates:							Specif	y. W.D	ite
ဂ်	72 h ''natu	Completed	15. Decedent (Specify only highes	's Education it grade complete	ed)		(Give	lent's Usual Occ kind of work don	e durina most i	of workir	ng 1	6b. Kind of B	usiness/Ind	dustry
2	within iene. than "	mp	Elementary/Secondary (0-12)	Colleg	e (1-4or 5	+)	life. L	OO NOT use retii	/			0		
A	be filed within 72 hours after death with the Marylan Hydjene. It Hydjene. It will than "natural", or items 23a or 28a-f show event, the Andical Exan, incrinist be notified at		17. Father's Name (First, Middle,	(and)				III ALI	ntenanc		(First, Middle, Ma		ernme	nt
⊆ .	ould be fi Mental H arked ot atic ever	Be											ne)	
5	2 should be and Menta Is marked raumatic ev	ပ	George Ira B			-	405 14-77-	- Add (Ot			Marie Kii		01-1-7	0-40
	d 2 sl th an 7 Is r traur	1	19a. Informant's Name/Relationsl Shirley Steven		aught	T.					l Route Number,	,		,
₩.	1 and Health em 27		20a. Method of Disposition	5 (1)	augnic			sition (Name of	Ave.		erstown,	Mary 1. Oc. Location		
פֿר	Pages nent of ant: If It ary or o		1 ☑ Burial 2 ☐ Cremation	3 🗆 Removal fr	om State	cerr	netery, cren	natory or other pi	· · · · · ·	Apri	1 23,		•	·
аппо	그 는 쁜 등		4 Donation 5 Other (Sp			Ring		Cemeteru . Name and Add						aryland
מ	Depar Impor any Ir		21. Signature of Funeral Service.	Icensee	·	11011					.L. Davi			
		4	23a. Part 1. Enter the disease, or	complications th	at caused								aryıa	nd 21783 Approximate
			shock, or heart failure. List	only one cause of	on and lin	ne.	La ca	of the mode of d	ying, soon as o	sardiac o	respiratory arres	J.,		Interval Between Onset and Death
੍ਰ F	hysician /Medical		disease or condition resulting in death)	a	(41)	LCINI	ma	0(1)						2-5 Month
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		e.	Sequentially list conditions,	b. Due	to Ores	в соввеснег	nne off:							
	ured Insit	min	Sequentially list conditions, if any leading to an additional cause. Enter Underlying Cause (Disease or injury that initiated events		,		-							
	n and	Examiner	resulting in death) Last	c Due	to (or as a	a consequer	nce of):							
	icate be executed physician and the burial-transit	dical		d										
		edi										-10		
Š	ines that the death certifications is signed by the attending I be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant			of pregnanc		1				23d. Da	ate of delive	ery
ַ נ	dear	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ P	regnant at	2 ☐ Fetal de t time of dea] Ectopic pregna] Other <i>(specify)</i>				Me	onth	Day Year
ָר כ	by th	hys	9 Unknown	900	nknown					_				
'n	gued ge de	by P	Part II. Other significant condition	ns contributing t	o death bu	ut not resultin	ng in the ur	derlying cause g	jiven in Part I.		23e. Did toba	cco use con	tribute to th	ne cause of death?
cords	en si		DEMENTI	H116	UEIL	E					1 X Yes	2 □ No	3 ☐ Prob	pably 4 🗌 Unknown
ָ ט	as be	bet	· ·								24a. Was an	24b.	Were auto	psy findings available
<u>ר</u>	Autonomy Priystoan: The law required and and the state of the funeral director, page 2 should by the funeral director, page 2.	Completed									autopsy perform 1 □Yes 2	ed?	death? 1 ☐ Yes	mpletion of cause of
ומ	stor, I	Be	25. Was case referred to medical examiner?						26. Place of	of Death	(Check only one,			2010
>	direc	၉	1 Yes 2 No	Hospital: 1	☐ Inpatie	nt 2 EF	R/Outpatien	t 3□DOA	ther: 4 Nurs	sing Hon	ne 5 🗆 Residen	ice 6 ☐ Otl	ner (Specif	y)
) = 1	ffer th		27. Manner of Death 1 Natural 5 □ Pending	28a. D	ate of Injur Ionth, Day	ry 28 v, Year)	3b. Time of Injury	28c. Inj		- 1	8d. Describe how			
HOISIA	be fu	ăţ	2 Accident investig	ation					□Yes 2□N	lo				
	ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Pl	ace of Inju uilding, etc	ry - At home c. (Specify)	e, farm, stre	et, factory, office	•	2	8f. Location (Stre City or Town,		per or Rura	l Route Number,
ָל ב	ral D	ē								- 0				
	The nospital or Attending Injection: The law requires that the pagin certificate within 24 bounds after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifyln (Check only one) 2 Medical I	Examiner: On th	the best on the basis of nanner sta	examination	edge, death n and/or inv	occurred at the estigation, in my	time, date and opinion, death	d place, a h occurre	and due to the ca ed at the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
4	vithin Fo the	Med	29b. Signature and tipe of applifier	and n	iaillei sta	(/		29c. Licei	nse number		29	d. Pate signe	d (Month,	Day, Year)
F	- s i o		ATTOMINE	11/16	DICE	7 No	HTM	7	106	>		Anni	18.	2008
		-	30. Name and address of person	who completed o	ause of de	eath (Item 2:	3a) (Tyne. I	Print)	1 / - 0	· /		Mille	7 /	
			STEPHEN E. 1	METEA	ENI	(111)	1342	4 Pat	WE A	Inc	En (rea	cn, U	11 2	7/747
	Stat		31. Date filed (Month, Day, Year)		2. Registra	ar's Signatur	e free	de la			• • • •	1		
	Registra	r	APR 2420	JUB AUG	SE MILI	J.J.	1	701						

08-02523

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Athena Castillo State of Maryland / Department of Health and Mental Hygiene 2008 | 329 | 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30, 2008 **Medical Examiner** 1325 hrs Athena Faye Castillo 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 110 South Eutaw Street Room 1060 Baltimore **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Days Hours Director Country) MD 219-73-2297 М 2_X_F Yrs 2005 Nov 1, Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 X No must be notified at once. MD Montgomery Silver Spring hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 Waterford Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes Widowed Yes, Give Year 1xx Yes 2 No specify: Mexican 4 Divorced Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n College (1-4 or 5+) Itimore, MD 21215-0036 0 Never Worked 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mark A. Castillo Amy A. Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy A. Castillo / Mother 412 Waterford Road, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Apr 8, 2008 Alexandria, VA Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and 'Medical Death a. Drowning Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical the attending physician and for use as the burial -UNPENDED AMENDED The law requires that the death certificate be Records, P.O. Box 68760. IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown cate has been signed by page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes ٩ 27. Manner of Death 28a. Date of Injury FOUND: After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject was drowned 1 Natural FOUND Yes 2 V No Director: d in by the f Pending 2 Mar 30, 2008 1317 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 110 South Eutaw St Room 1060, Baltimore, MD Funeral] determined (Specify) Hotel 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 O.C.M.E. March 31, 2008 who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year APR 0 9 Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

2008

OCME

08-02524 Austin Castillo

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		1- For State Registrar	Certificate	e of Death		Re	g. No.	10 1329
Physici		Decedent's Name (First, Middle,Last)		-	···	2. Date of Deat Month		3. Time of Death
ledical Exam	iner	Austin Robert Castillo				March 30,	2008	1325 hrs
Ì		 Facility Name (if not institution, give street and number 110 South Eutaw Street Room 1060 	mber)		or Location of Deat	h	4c. County of Deat	h
_				Baltimore				
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Ye Months Da		_	h(MM/DD/YYYY) 9. Bi Forei	an
Director		214-69-6890 1 _X M 2 F	4	Yrs.	, , , , , , , , , , , , , , , , , , , ,	Oct 20,	2003 Co	DuntryMD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation				10d. Inside City Limits
* .								1 Yes 2 X No
daryland 28a-f show 1 at once.	tor	MD Montgomery 10e. Street and Number	Silve	r Spring		1	(110)	
th the Maryland 23a or 28a-f sho	Director			10f. Zip Code		10	g. Citizen of What Cou	intry'?
ith the 23a c		412 Waterford Road		20901			USA	
ath w items	Funeral	11. Marital Status 12. Was Dec 1 Never Married 2 Married Armed F	orces?	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (S an, Mexican, Puert	specify Yes or No- o Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
ter de		3 Widowed 4 Divorced If Yes, Give Yes	2X No	1 Yes 2 N	o specify: Mos		Sanaku **	
urs af tural	d by	or Dates: 15. Decedent's Education (Specify only highest grades)		cedent's Usual Occup	I'le:	kican work done	Specify: Whi	
72 hor 1 "na 1 Exa	Completed	Elementary/Secondary (0-12) College (1	dur	ing most of working lif				
036 ithin 72 ne. r than '	ldu	0	Ne	ver Worked				
5-0(Hygier other	Cor	17. Father's Name (First, Middle, Last)	<u> </u>		18.Mother's Nam	e (First, Middle, N	I faiden Sumame)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Mark A. Castillo			Amy A.	Ward		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers 7 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print)	19b. M	failing Address (Stre	eet and Number or	Rural Route Num	ber, City or Town, Stat	e, Zip Code)
		Amy A. Castillo /Mother		Waterford R				
re, MC s Land 2 s of Health ar If item 27 ter traum:		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal fr		isposition (Name of co or other place)	emetery,	Date	20c. Location - City o	r Town, State
imore, MD 2 Pages I and 2 shou ment of Health and I tant: If item 27 is n or other traumatic		4 Donation 5 Other Specify:		tan Cremator	y Apre	3, 2008	Alexandria,	VA
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Funeral Service Licensee		22. Name and Addres	ss of Facilityrano	cis J. Col	lins Funeral	Home Inc.
		Linchen Hole					pring, MD 209	01
Physician /Medical		23a. Part I. Enter the disease, or complications that c failure. List only one cause on each line.	aused the death. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a						Death
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	ě		consequence of):					1
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760, froate be executed g physician and the burial - transit	/Medical	UNPENDED AMENDED						
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5876 rtificate ling phy	~	23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic pregn	ancy		Day Year
Box 68 e death certifi the attending ed for use as t	Physiciar	1 Ves 2 No 9 Hoknows 4 Pregn	ant at time of death 5	Other (Specify)			9	
· £ ~£	جُ	9 Olikiic				00 5:11		
of Vital Records, P.O. Box 68 and Physician: The law requires that the death certif After this certificate has been signed by the attending neral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause	given in Part I.		bacco use contribute to	bably 4 Unknown
duires quires en sig	ted					24a. Was a		utopsy findings available
Orc law re has be 2 sho	Completed					autop	sy prior to	completion of cause of
Re(The icate	등					perfor 1 Yes		es 2 No
tal cian: certif	Be	25. Was case referred to medical examiner?			ce of Death (Check	only one)		
Physical direction	ဥ	1 Yes 2 No	npatient 2 ER/Outpa				Residence 6 Othe	er: Scene
n of Name of Physics After the funeral	ä	1 Natural EO(MR)	Day,Year) FOUND		ury at Work? Yes 2 ✔ No	Subject was	ow injury occurred drowned	
SiO Atten r deat ector by the	cati	2 Accident Investigation Mar 30,	2008 1317 hr	s	U			
Division pital or Attendio ours after death.	Certification:	determined (Specific)	of Injury - At home, farm,	street, factory, onice	building, etc.	or Town, S	tate) taw St Room 1060, I	ural Route Number, City
lospii 4 hour		29a. Certifier		and at the time	lata and slave an			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certi completely, filled in by the funeral director	Medical	(Check only one) 1 Certifying Physician: To the best one) 2 Medical Examiner:On the basis of	of examination and/or inves					
To with Con	Mec	29b. Signature and title of certifier	ated.		se number		29d. Date signed (Mo	
3		Dit · A. D	00	0.0	.M.E.		March 31, 2008	, , ,
	}	30. Name and address of person who completed caus	e of death (Item 23a)					
			int Medical Examine	er 111 Penn S	treet, Baltimo	re, MD 21201	I	
	ate	31. Date filed (Month, Day, Year)	gistrar's Signature	a off a				
Regist	rar	APR 0 9 2008	un st ap					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 13293 1. For State

		Registrar		Certifica	ate of	Death				F	teg. No.	6-a O	
Physici		Decedent's Name (First, Middle								Date of Dea Month		Year	3. Time of Death
ledical Exami	ner	Anthony Nathaniel							I	Month March 30			1325 hrs
)		4a. Facility Name (if not institution	-		4	4b. City, Tow		ocation of	Death		4c. Co	ounty of De	ath
		110 South Eutaw Stree				Baltimo							
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birt	hday)	If Under 1 Months	Year Days	If Under Hours	24Hrs. 8 Min.	B. Date of B	rth(MM/DD/	TEOR	Birthplace (State or eign
Director		216-63-5065	1 X M 2 F	6	Yrs		Days	110013		Dec 15	, 2001		Country) MD
		Usual Residence of Decedent											
w any		10a. State 10b. County	110	oc. City, Town	or Locati	on							10d. Inside City Limits
daryłand 28a-f show 1 at once.	ō	MD Montgon	mery	Si	lver	Spring							1 Yes 2 X No
Maryl 28a-	Director	10e. Street and Number				10f. Zip Co	de				10g. Citizen	of What Co	ountry?
th the Maryland 23a or 28a-f she notified at once	ة	412 Waterford Ros	ad			209	01				USA		
with ms 2.	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.		s Decedent					0- 14.		erican Indian, Black,
death or ite	ŭ	1 X Never Married 2 Ma	rried Armed Forces?	No	10.1	es, specify C						White, etc	
after al", o	by F	3 Widowed 4 Divo	orced If Yes, Give Year or Dates:		1 X	Yes 2	No	specify: 1	Mexica	n _	Sp	^{ecify:} Whi	ite
hours af 'natural Examin		15. Decedent's Education (Spec	ify only highest grade compl			t's Usual Oo ost of workin	cupatio	n (Give ki	nd of work	k done	16b. Kind	of Busines	ss/Industry
6 1,72 h cal E	mpleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during in	OST OF WORKIN	y me. L	JO 1401 U.	se remed	,			
0036 within 72 iene. rer than "	m d	0	:		Nev	er Work	ed						
215-(be filed vatal Hygi rked oth	ပ္ပ	17. Father's Name (First, Middle,	Last)				18	3.Mother's	Name (Fi	irst, Middle,	Maiden Su	mame)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be	Mark A. Castillo							A. Wa				
O용원호호	ပ	19a. Informant's Name/Relationsh		[19t	b. Mailing	g Address (Street	and Numb	er or Rura	al Route Nu	mber, City o	or Town, St	ate, Zip Code)
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is n		Amy A. Castillo /	Mother			terford							T Ot-1-
		20a. Method of Disposition 1 Burial 2 Y Cremation	3 Removal from State	20b. Place of cremat		ition (Name ner place)	or ceme	etery,	U	ate	20c. Loc	ation - City	or Town, State
imore Pages 1 nent of F ant: If i		4 Donation 5 Other Sp			olita	n Crema	tory		Apr 8,	2008	Alexa	andria,	VA
Baltimore, permit. Pages I an Department of He. Important: If ite injury or other tr		21. Signature of Funeral Service I			22. N	lame and Ad	dress c	of Facility	Franci	sJ.C	ollins	Funera	al Home Inc.
ក ខ្មែរ		Chicken Cole 500 University Blvd W, Silver Spring, MD 20901											901
Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva											Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease	a. Drowning										Death
		or condition resulting in death)	Due to (or as a consequent	uence of):									
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760, cate be exc physician he burial -	Physician/Medical	UNPENDED	AMENDED										
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68 certifi nding se as	ian	past 12 months?	e 1 Live birth 4 Pregnant at tir	ne of death		tal death	3 _	Ectopic	pregnancy	У	Mo	onth	Day Year
Box 6 e death cer the attendi ed for use	/sic	1 Yes 2 No 9 Unk	nown g Unknown	ne or death	ō 🔛 Ot	her (Specify)				4		
J. B. I the de by the	Ą.	Part II. Other significant condition		ut not resulting	g in the u	ınderlying ca	use giv	en in Parl	t I.	23e. Did	tobacco use	contribute	to the cause of death?
P.O rres that is signed b	ð					, ,	ū			1 Y	es 2 🗸 N	lo 3 F	Probably 4 Unknown
ds, equire een si	ted						-			24a. Wa	san i	24b. Were	autopsy findings available
Sor law n has b	힏									auto	psy ormed?	prior death	to completion of cause of
ian: The certificate extor, page	Completed		*							1 Yes	2 No	1 🗸	
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Physical directions	2	1 ✓ Yes 2 No	ı ınpaticiti		utpatient		`		Nursing F		_	e 6 🗸 Ot	ther: Scene
Division of Vital Records, P.O. Box 6 Hospital or Attending Physician: The law requires that the death ce 24 hours after death. Funeral Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use	Certification:	27. Manner of Death 1 Natural 5 Panel	28a. Date of Injury (Month, Day, Yea FOUND:	r) 28b.	Time of I JND:	njury 280		at Work?	ls.		how injury		
sion attend death death y the	äţį	Fellul	tigation Mar 30, 2008	1317	7 hrs	1		es 2 🗸 I					
ivis	إ≝ا		not be 28e. Place of Injur		arm, stre	et, factory, of	fice bui	ilding, etc.		or Town,	State)		Rural Route Number, City
Divisspital or hours after neral Direction of the contraction of the c	Ö	4 V Homicide	mined (Specify) Hote	!					111	0 South E	utaw St R	oom 1060	, Baltimore, MD
To the Hospital within 24 hours To the Funeral	g	Tonican any	ysician: To the best of my liner:On the basis of exami	_									
To the within To the complete	Medical	2 🗸	and manner stated.	nation and/or i	rivestiya				urred at tr	le time, dat			
	2	29b. Signature and title of certifier	\bigcap					number				- ,	Month, Day, Year)
3		total lan	- tolld	· puo		- -	D.C.M	I.E.			March	31, 200	8
_		30. Name and address of person		' '									
		Patricia Aronica-Polfak			niner	111 Pen	n Stre	eet, Bali	timore,	MD 212	U1		
St Regis	ate	31. Date filed (Month, Day Year)	2008 32 Registrar's	Signature	hoo	15 p							
- Joyan S	ut: Ir	APR 0 9 2008 Beggin & Species											

DHMH 17 Rev 1/2001 OCME 2006

	ga.	D
CHERRY, MELVIN	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Health and Montal Huniana.

			For State Registrar	State of Maryland		tificate of l			Reg. No.	008	1329
	Diii		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia Medic		Melvin Bryant	Cherry				APRIL	1	2008	8:00 PM
)	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death			nty of Death	
	,		Doctor's Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Lanhan If Under 1 Year	m If Under 24 Hrs.	8. Date of Birtl	h	ce Geo	orge's place (State or Foreign
В	Funeral Director		1 🔯	M 2□F	Yrs.	Months Days	Hours Min.	(Month, Day	v, Year)	Cour	nington, DC
Sec.	II		579-72-9226 Usual Residence of Decedent	51	1			April	J, 19J		
	yland how		10a. State 10b. County	10c. City, 1	own or Lo	cation				1	10d. Inside City Limits
	e Mar ta-f s	ctor	Maryland Prince Ge	orge's Seat	P1ea	sant					1 Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		·
	s 23a		500 - 69th Place	2. Was Decedent Ever in U.S.	10 1	20743	lienanio Origin? (Sr	pacify Ves or No-		d Stat	
	ter de Item ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	13. 1	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	В	lack, White,	etc.
36	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	1		☐ Yes 2M No	Specify:		Spe	cify: B1	Lack
ğ	2 hou	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occup	ation during most of wor	king	16b. Kind of	Business/In	dustry
2	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	ning			
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show the the Medical Examiner must be notified at	Co	12 years		Elec	trician_	18. Mother's Nam	o /First Middle		rnment	
and	be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)					ie Bell	waiden sun	iain o)	
ž	2 should be filed and Mental Hygi is marked other aumatic event, <u>it</u>	P_	John Cherry 19a. Informant's Name/Relationship (Type)	ne Print)	19b. Mailin	a Address (Street	and Number or Ru		er. Citv or Tov	vn. State. Zit	Code)
Maryland 21215-0036	and 2 s ealth an n 27 is i er trau		Mary Cherry - Wife	´		•	ace Seat				,
ē,	一工元章		20a. Method of Disposition		e of Dispo	sition (Name of natory or other place	ce)	Date	20c. Locatio	n - City or To	own, State
E O	Pages nent of I int: If ite		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		lem. Park	1	1 10, 20	08 La	ndovei	c, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Si nature of Funeral Service Licens		22	. Name and Addre	ss of Facility St				
<u> </u>	8 3 2 6 8	0 11	1 Kopulax	VERSON			ng Road,			, DC 2	
r			23a. Part . Enter the disease, or compli shock of heart failure. List only on	e cause on each line.							Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition	METASTAT	16 .	HERMO	Cerno	are (pr	WC, 4	020	
	/Medical Examiner		resulting in death)	Due to (or as a consequent		4510N					
	14 500	je.	Sequentially list conditions b	Due to (or as a conseque	-	7 3 7 0. 4	•				
	uted J ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executed	(240)	HUL	のできょ	1 .				
Ć	fficate be executed g physician and as the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseque	nce of):						
68760,	ite be iysicia ne bur	edical	d								
			IF FEMALE:			-				<u> </u>	
Вох	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnand 1 □Live birth 2 □ Fetal d	eath 3	Ectopic pregnanc	у		- 1	Date of deliv Month	rery Day Year
0	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	th 5L	Other (specify) _					·
P. O.	The law requires that the death certit thas been signed by the attending tage 2 should be detached for use a	Ph	Part II. Other significant conditions cor	tributing to death but not resulti	ng in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use c	ontribute to 1	the cause of death?
ds	uires sign Id be	d by	END-STAGE	2 than	171 2	EASC		1 🗆 '	Yes 2 □ No	o 3 Pro	bably 4 🛮 Unknown
00	w req	Completed						24a. Was		lb. Were aut	opsy findings available
Re	The lav e has age 2 :	dmc						autor perfo 1⊡ Yes	rmed?	prior to co death? 1 \(\sum \text{Yes}	omipletion of cause of
tal		Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110
Ž	Physicl this cer al direc	TO B	examiner?	lospital: 1 Depatient 2 EF	R/Outpatier	it 3□ DOA Oth	ner: 4 🗆 Nursing H	lome 5 ☐ Resi	dence 6 🗆	Other (Speci	ify)
n 0	ng Pt fter tt neral		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time o	Wor		28d. Describe I	how injury oc	curred	
Sio	Attending Physiclan: r death. ector: After this certifics by the funeral director. I	catic	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No				ID I North
Division or Vital Records,	or At after d Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	e, tarm, str	eet, ractory, office		City or To	wn, State)	imber or Hur	ral Route Number,
_	Hospital 24 hours a Funeral rely filled		29a. Certifier 1 Certifying Physics	sician: To the best of my knowl	edge, deat	h occurred at the ti	ime, date and place	e, and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	n and/or in	vestigation, in my	opinion, death occi	urred at the time,	date and pla	ce, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sig	gned (Month	, Day, Year)
			1	WO		176	01860		412	-108	
0	(2)		30. Name and address of person who co				<i>"</i> • •	,			
			45 GEZ	43100VN 8	5118 G	bood Luc	CIL Rdi,	Lanh	cem, 1	mD.	20106

Registrar

31. Date filed (Month, Day, Year)
APR 0.9 2008



			For State	State	of Maryl		artment of F			/ / /	08	13295
	-		Registrar Decedent's Name (First, Middle)	fle, Last)		007	imeate or i	Douin	2. Date of De		V	3. Time of Death
	Physicia /Medic			MARY		CRI	JTCHLEY		04		Year 08	3:15 A M
5	Examin	er	4a. Facility Name (If not institution WMHS-BRADDOCK		number)		4b. City, Town, or CUMBER	r Location of Deat T.AND	h	4c. County		
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □	F .	yrs. last birthday) Yrs.	If Under 1 Year Months Days			h v. Year)		ice (State or Foreign
	Director		215-56-8999 Usual Residence of Decedent		. 00				Dec 1	1947		
	larylan show	ř	10a. State 10b. Count	legany	10c.	City, Town or Lo	town				10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	Vhat Countr	
	th with use 23a of ust be	ral D	16901 E. Wils	son Road				21555		U	JSA	
o O	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show if them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	rried Armed	Decedent Ever i d Forces? es 2 1 No . Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ 🏡	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black	e - Americai k, White, et	tc.
-0020	hours	ed by	3 X Widowed 4 ☐ Divorce	d Year o	or Dates:	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	Whi	
<u>-</u>	thin 72 e. an "na Medik	Completed	(Specify only high Elementary/Secondary (0-12)	est grade complet	ed) ge (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo d)	rking			,
177	iled wil Hygien her th nt, the		12 17. Father's Name (<i>First, Middle</i>	a / act)		home	emaker	18 Mother's No.	me (First, Middle,	own ho		
	should be filed within nd Mental Hygiene. marked other than ' matic event, the Me	To Be	Matthew M		olly				Mary A		(e)	
Mary	d 2 shouth and N Is and N Is mark		19a. Informant's Name/Relation Jeanie Gross		daugh	19b. Mailii ter 51	ng Address (Street 8 Pine Ave	and Number or R	ural Route Numb Cun	er, City or Town, nberland	State, Zip (D 21502
Sec.	es 1 and 2 of Health fitem 27		20a. Method of Disposition 1 MBurial 2 Cremation		om State	b. Place of Dispo cemetery, cre	matory or other plac	ce)	Date	20c. Location -	City or Tow	ın, State
Dallillion	Pa in it		4 □ Donation 5 □ Other (21. Signature of Funeral Service	Specify)	om state	Glendale C		ss of Facility	4/21/2008	Flintst	tone	MD
۵	permit. Departr Importe any Inju		1////////	/////	? •		2. Name and Addre Scarpe 108 Vir	ıllı Funeral H ginia Avenu		and, MD 215	502	
			23 - art1. Inter the disease of shock, or heart failure. Lie	or complications that st only one cause	at caused the con each line.	death. Do not ent		_	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Duc	to (or as a con	3 C	ANCE	R			10	YEAR
	Examiner		Companielly list conditions	h	to (or as a con	sequence ory.						
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	e to (or as a con	sequence of):						
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0.00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Li 4 □ P	ve birth 2 regnant at time nknown	Fetal death 3[⊒Ectopic pregnanc ⊒ Other (specify) _	у			te of deliver	y Day Year
<u>ທຸ</u>	requires that the een signed by th	by Ph	Part II. Other significant condi	tions contributing	to death but not	resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
cords	v requi	eted							1 2 24a. Was			ibly 4 🗆 Unknown
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VILA	Physician: this certific ral director,	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ ₩6	Hospital:	Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Oth	or.	eath <i>(Ch</i> eck only o Home 5 ☐ Resi		ar (Snacify	
010	Attending Phy r death. ector: After thi by the funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pend		ate of Injury Month, Day Yea	28b. Time o	of 28c. Inju			how injury occurr		,
DIVIS	I or Atter after deal Director	Certification:	3 Suicide 6 Coul	d not be	lace of injury - inju	At home, farm, st pecify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certify (Check only one) 1 Medic	al Examiner: On t	the best of my he basis of exam manner stated.	knowledge, deal	th occurred at the ti	me, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certif	ier	-11	A.	29c. Licens			29d. Date signed	d (Month, E	Day, Year)
				ma	Do	ma	, 12	540	204	4/	18/	8
			30. Name and address of person	on who completed	cause of death	(Item 23a) (Type,	Print)	Mari	land.	21502	,	
	Sta		31. Date filed (Month, Day, Yea		2. Registrar's S	ignature	K)) , , , , ,	10010 8			
	Registr	ar	APR 2 4	2000		1	and the same of th					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** HAZEL 120 2008 0 /Medical 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Montgomery Montgomery General Hospital 01ney If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Days Hours Min. Months 1 ☐ M 2 🖺 F 79 Yrs. August 10, 1928 Pennsylvania Director 168-22-4297 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f ahow other traumatic avent, the Medical Examiner aust be notified at 1 ☐ Yes 2 🛣 No Director Silver Spring **Maryland** Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. or items 23a 20905 1717 Briggs Chaney Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 XWidowed 4 ☐ Divorced Caucasian natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Dietary Worker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of Jane Elizabeth Stumme 2 Paul Edward Reep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1717 Briggs Chaney Road, Silver Spring, Maryland 20905 Fred M. Cermak, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Department of the important: If Ite any injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) George Washington Cemetery 04/13/2008 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consec Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, should be 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No page 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 / Inpatient Certification; To 2 ☐ ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: / 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Funeral I filled i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062261 08 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sadik M. Ali, M.D., 251 Antietam Street, Hagerstown, Maryland 21740 31. Date filed (Month, Day, Year) Registrar's Signature State APR 0 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 13297

Lawrence Kenne		1- For State	ate of Maryla	•	rtment of		d Mental	Hygiene	Reg. No.	2008	13297
Physici Marical Exami	an/	Registrar 1. Decedent's Name (First, Midd Lawrence Kenne		n aka	Lawrenc	e Kennet	ch Deat	2. Date of Do Month April 15,	eath		ne of Death 102 hrs
<u>ز</u>	į	4a. Facility Name (if not institution 2702 Oak Leaf Court	on, give street and n	ımber)	44	o. City, Town, or Odenton	Location of De	eath	4c. County Anne A		
Funeral Director		5. Social Security Number 214-72-2447	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Yea Months Day		1.6-	Birth (MM/DD/YYY . 27, 19	Country)	e (State or Foreign land
id de any	_	Usual Residence of Decedent 10a. State 10b. County			Town or Location					_	Inside City Limits Yes 2 X No
the Marylan	Director	Maryland 10e. Street and Number 4813 Great (Montgome Dak Road	eryl	Rock	ville 10f. Zip Code 20853			10g. Citizen of V	Vhat Country?	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and file in a file may be marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 XX 3 Widowed 4 Div		2 No	If Ye		n, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	Wh	ce - American In ite, etc. White	dian, Black,
6 n 72 hours aft an "natural"	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest gra		16a. Decedent during mo	's Usual Occupat st of working life	tion (Give kind . DO NOT use	e retired)	16b. Kind of E	Business/Industr	on Technolo
215-0036 Refiled within 77 Rel Hygiene. Red other than nt, the Medical	Be Comp	17. Father's Name (First, Middle David Kennetl	, Last)		VI OI	COMMICTION	18.Mother's N		e, Maiden Surnam		
more, MD 2121 Pages I and 2 should be fill then of Health and Mental ant: If item 27 is marked or other traumatic event,	ToE	19a. informant's Name/Relation: Wendolyn Adams			4813	Great (Dak Roa	d, Rock	Number, City or To	D 20853	
Baltimore, permit. Pages I am Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	pecify:	rom State	Place of Disposit crematory or oth tropoli	_{er place)} tan Crer	natory	April 17 2008	7	n-City or Town	State Virginia
Balt Balt Depart Import Import Infort		21. Signature of Funeral Services (M) 23a. Fart I. Enter the disente, o	Cerlo	caused the death	Fr.	ame and Address ancis J O Unive	. Colli	ins Fune:	ral Home Silver	Inc. Spring.	MD 20901
'Medical ⊿xaminer	ner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	e on each line. e a. <u>Hyperte</u> Due to (or as b. Due to (or as	nsive Athe a consequence o	erosclerot f):					Be	tween Onset and Death
cuted nd transit	I Examine	(Disease or injury that initiated events resulting in death) Last	C.	a consequence o	f):			_			
60, ate be executed hysician and e burial - transit	Medical	X UNPENDED IF FEMALE:		1,23a,27 F		78 4/25/08	amh		23d. Date	of delivery	
Records, P.O. Box 68760. The law requires that the death certificate icate has been signed by the attending physpage 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in t past 12 months?	he 1 Live	birth nant at time of de	2 Fet	al death 3 ner (Specify)	Ectopic pr	egnancy	Month	Day	Year
cords, P.O. Belaw requires that the de has been signed by the should be detached for	þ	Part II. Other significant condi	tions contributing	to death but not r	esulting in the u	nderlying cause	given in Part I		d tobacco use cor Yes 2 ✓ No		
Records The law requents that has been page 2 should	Completed	<u> </u>						pe	as an 24b utopsy erformed? es 2 • No		findings available etion of cause of
/ital ysician: uis certif director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 e of Injury	ER/Outpatient 28b. Time of In	3 DOA	Othor:	lursing Home 5	Residence 6	Other: Scen	ne
Division of Vital Divisions: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	2 Accident Inve	ding estigation	ce of Injury - At h	ome, farm, stree		Yes 2 No	28f. Locatio	on (Street and Num n, State)	nber or Rural Ro	oute Number, City
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier 1 Certifying F	hysician: To the beaminer: On the basis and manner	of examination a		ion, in my opinio	n, death occur		ate and place, and	d due to the cau	
5 point 1 va	Σ	29b. Signature and title of certification	weless			29c. Licens	M.E.		April 16,	gned (<i>Month, D</i> 2008	ay, Year)
	1 ()		Assistant Medic	al Examiner	111 Penn	Street, Balti	more, MD	21201			
	tate	31. Date filed (Month, Day Year	2008	egistrar's Signati	The Manual	150					

			1- For State of Maryland / Dep	eartment of Health and Mertificate of Death	_	giene	08	132	98
*	Discontact.		1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of [Death
	Physici /Medic		Keyon Antonio Dames		April		008	3:23	P^{M}
E	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County	of Death		
		ŧ.	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Bir	Montg			- F t
F	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	(Month, Da	y, Year)	Coun		roreign
150	N. Palita — agai stanagaga	8	Usual Residence of Decedent		Dec. 15	5,2000 p	Mary1	and	
	nyland how	L	10a. State 10b. County 10c. City, Town or L	ocation			1	0d. Inside City	
	ne Ma 8a-f s ptifiec	cto	MD Montgomery Aspen Hi					1 X Yes	2 □ N0
	vith th	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of V	/hat Coun	try?	
	sath v	eral	3609 Peartree Court 11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was December of Hispania Origin? (See	noifu Voc or No	USA 14 Bace	- America	an Indian	
10	fter d	Funeral Director	11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Ever in U.S. 13. 13.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Blac	k, White,		
036	ursai al', ol Exam	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No Specify:		Specify	Blac	k	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed		edent's Usual Occupation	ina	16b. Kind of Bu			
2	ithin an "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	,,g	,,			
121	lled w Hygier her ti nt, th	S	1 17. Father's Name (<i>First, Middle, Last</i>)	N/A 18. Mother's Name	/First Middle		/A		
Maryland	d be fi	Be c	Tramell Robinson	Robin Da:	, ,	, Maiden Surnam	e)		
<u>Z</u>	should bd Me mark matik	우		ling Address (Street and Number or Rura		er. Citv or Town.	State. Zip	Code)	
Σ	s 1 and 2 soft Health and Item 27 is other trau		1/1	Peartree Court, Asp				,	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of E	Date	20c. Location -	City or To	wn, State	
<u>E</u>	Page nent ant; II ury o		4 Donation 5 Other (Specify) National	Harmony 4/10		Landove			
alt	eparti eparti porti ny inj			22. Name and Address of Facility ${ m McG}$					
8	20 E 9 9	Al I	7.00	400 Georgia Avenue			DC 2		
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac of	or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
6	Physician / /Medical		resulting in death)	Sickle Cell Anemia	ı				
	Examiner		Due to (or as a consequence of):						
	E_B_	er	Sequentially list conditions, if any leading to immediate b. Due to or as a consequence of a						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ó,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):						
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9 x	death certifics e attending ph d for use as th	Physician/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy						
Box	atten for us	cian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Dat Moi	e of delive nth	,	ear
P.O.	0 0 0	ysi	1 Yes 2 No 9 Unknown 9 Unknown						
	The law requires that the date has been signed by the page 2 should be detached	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contr	ibute to th	e cause of de	ath?
or Vital Records,	equire en sig ould bo	ed b			10	Yes 2∏ No	3 ☐ Prob	ably 4 □U	nknown
ecc	2 3 3	plet			24a. Was		Vere auto	psy findings a	vailable
<u> </u>	The ate h	Completed			perfo	ormed?	l <u>ea</u> th?	2 ∑ No	U30 01
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only o	one)			
or	Attending Physician: r death. ector: After this certifici	٩	1 Yes 2 No Hospital: 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Inpatient Fig. 1 Fig. 1 Fig. 2		dence 6 Othe	·· · · · ·	/)		
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Division	Atten r deat ector.	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s'			Street and Numb	er or Rura	l Route Numb	per,
ă	s after al Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or To	wn, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Check only 2 ☐ Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the red at the time,	cause(s) and ma date and place,	nner as st and due to	ated. the cause(s)	
	To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed	/Month.	Dav. Year)	
	/\		See Skiatent M	D20429					
	4		30. Name and address of person who appleted cause of death (Item 23a) (Type			April 4,	2000		
_	1		Ellen S. Rigterink, MD 1500 Forest G1		ring, M	D 20910			
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	. As a					
	Registr	ar	APR 0 9 2008 Believe 15 Apr	use)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2, <u>11:</u>56 P^M Freddie April 2008 Mae Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8107 Redview Drive District Heights Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days 1□M 2 F 244-34-2530 92 28, 1915 North Carolina Sept Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1**X**Yes 2 □ No Directo Prince George's Maryland District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8107 Redview Drive 20747 United States death . Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may lajury or other traumatic event, the <u>Medical Examine once.</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Black <u></u> 3 X Widowed 4 ☐ Divorced ear or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housekeeper Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freddie Gamble Ann Jackson ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sincere Toliaferro - Daughter 5318 Silver Park Dr. #7 Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 8, 2008 Landover, MD Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Servi 4001 Benning Road, NE Washington, DC 20019 23a. Part l Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial Infarction/ CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease sician and burial-tran resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Chronic Kindney Failure Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 💢 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hyperlipemia, CVA, Cachexia, Dementia 1 Tes 2 No 3 Probably 4 KUnknown Completed Type II Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760 nours after death.

Ineral Director: After this y filled in by the funeral di To the Hospital o within 24 hours aft To the Funeral Di

State

31. Date filed (Month, Day, Year) APR 1 0 2008

29b. Signature and the of centifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diotr L. Grojec, M.D. 32. Registrar's Signature

(Month, Day Year)

Registrar

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0046671

6400 Marlboro Pike District Heights, MD 20743

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 8, 2008

State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#23a.Prt1.PerPhys.PGC4-16-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:30 AM Golie Dunn 04 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth 1918 (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 577-22-7095 September 15 Rocky Mount, NC Director 89 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at DC Washington, DC 1 √ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 621 Powhatten Place N.W. USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Black Specify: 3 N Widowed 4 □ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Dunn Marylina Dunston Whalem ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 621 Powhattan Place NW, Washington, DC Joann Dunn/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If Ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Cem. 04/14/2008 Laurel, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Senice Libensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be to (or as a consequence of) Examiner requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical as the IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been signage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending To the Hospital or Attendil within 24 hours after death. To the Funeral Director; A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1142033 4-5-08 30. Name and address of person who c te 1 ause of death (Item 23a) (Type, Print) Dr. Martin Portillo 501 North Frederick Rd. Bladensburg, MD 20876 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** WILLIAM CHARLES DAVIS P^{M} APRIL 2008 6 5:44 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 28 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Yrs. 250-48-0589 Director 75 SOUTH CAROLINA 1932 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If tem 27 is marked other than "natural;" or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 1√Yes 2 No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 GOLDLEAF AVENUE 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ NA IRFORCE If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th OFFICER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERNEST GREEN DAISY B. DAVIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVIS/WIFE FLORENCE 402 GOLDLEAF AVENUE CAPITOL HEIGHTS, MARYLAND 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEMETERY 4/15/2008 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 21. Signature of Juneral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherote **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Se Due to (or as a consequence of): hed by the attending physician detached for use as the hinter Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2₹ No 1∐ Yes 2 1 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 1 Impatient P 1 Tes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide त 24 hou. *he Funeral D स्थाहर 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uni

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 0 2008

32. Registrar's Signature

			_ FOI	epartment of Health and Mental Hygiene Certificate of Death Reg. No. 2008 13302
ţ	Physici /Medic		Decedent's Name (First, Middle, Last) PATRICIA DAVIS	2. Date of Death Month Day Year APRIL 2 2008 4:45 P
)	Examin		4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death CLINTON PRINCE GEORGE'S
ş	Funeral Director		577 - 62 - 1970 1□ M 2√ F 67 Yr Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year) Country) DEC. 3, 1940 WASHINGTON, D.
	the Marylan 28a-f show notified at	Director	10a. State 10b. County 10c. City, Town of Cap. 10c. Street and Number 10c. Street and Number 10c. City, Town of Cap. 10c. Street and Number 10c. City, Town of Cap. 10c. City, Town of	itel Heights 10g. Citizen of What Country?
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	3914 ELLIS ST., 11. Marital Status 1 □ Never Married 2□ Married 3 □ Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: UNITED STATES 14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	be filed within 72 ho ital Hygiene. d other than "natur event, the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) NURSE HEALTH CARE
ryland	2 should be filed and Mental Hygi Is marked other aumatic event, ti	To Be (17. Father's Name (First, Middle, Last) CLARENCE STOKES	18. Mother's Name (First, Middle, Maiden Surname) RACHEL ALSTON Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
re, Mary	1 and Health em 27 ther tr		TONYA R. DAVIS/DAUGHTER 23	7 SAVANNAH ST., S.E. #C WASH., D.C. 20032 Disposition (Name of Pate 20c. Location - Sity or Town, State
Baltimore,	permit. Pages Department of Important; If its any Injury or o		1 A Burial 2 Cremation 3 Hemoval from State	IVET CEMETERY 4/10/08 WASHINGTON, D.C. 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., D.C. 20002
8/60,	Physician and /Medical Examiner and the bruisi-transit	dical Examiner	23a. Pant 1. Enter the disease, in complications that cause d the death. In no shock, or heart failure. List ruly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death
O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9X Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 23d. Date of delivery Month Day Year
Records, P	The law requires that are has been signed b page 2 should be dete	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 2 4 2 4 4 2 4 4
DIVISION OF VITAL	nysician; nis certific director,	Certification: To Be C	2 Accident investigation	26. Place of Death (Check only one) Datient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) me of ury M 1 Yes 2 No
2	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral			death occurred at the time, date and place, and due to the cause(s) and manner as stated. for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the P. within 24 To the F. complete	Medical	29b. Signature and title of certifier Me Land Manner stated.	29c. License number 29d. Date signed (Month, Day, Year) 4/2/2008
	(2) Sta	ite	30. Name and address of person who completed cause of death (Item 23a) (T 31. Date filed (Month, Day, Year) 32. Registrar's Signature	467 old Branch Ave, Templehills, nd

			For State Registrar	State of	Marylan	•	artment of I		and Me	-	giene Reg. No.	2000	1000
	Physici		Decedent's Name (First, Midda Mbaimba	lle, Last) Daramy						2. Date of De		Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution Shady Grove Ho		er)		4b. City, Town, Rockvi		of Death		4c. C	ounty of Death	1
a.	Funeral Director		5. Social Security Number 578–33–3103	6. Sex 1 M 2 F 7.	Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir 9/23/1	th ay, Year) 933	Cou	nplace (State or Foreign intry) egal
	ath with the Maryland 5.23a or 28a-f show ust be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montg 10e. Street and Number 18036 Cottage	omery Garden Dr.	#101	y, Town or Lo German	10f. Zip Code	2087				en of What Cou	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorced (Specify only higher Elementary/Secondary (0-12)	If Yes, Give	es:	16a. Dece	Was Decedent of If Yes, specify Cult of Yes, specify Cult of Image 2 □ No dent's Usual Occuping April 100 NOT use retire Trader	Specify:			s	A. Race - Ameri Black, White Specify: Bla d of Business/li Priva	, etc. ack industry
Maryland 2	uld be filed v Mental Hygie Irked other i	To Be Co	17. Father's Name (<i>First, Middle</i> Noah	n, Last) Daramy				18. Mothe		(First, Middle Bun			ate
	l and 2 lealth a sm 27 Is	8	19a. Informant's Name/Relation Mohamed B. Sang 20a. Method of Disposition	, ,	20b. F	14713	Bubblin	g Spr	ing R		oyds,	· · · · ·	0814
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (21. Signature of Furral Service	Specify)	ate	MILY P	natory or other pla LOT 2. Name and Addr 474 Land	ess of Facilit	ty J.B		ins F	ar, Ser uneral MD 2078	Home
8760,	Physician /Medical Examiner physician and physician and physician and the physician with the physician and physician are physician and physician and physician are physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are physician and physician are physician and physician are physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are physician and physician are physician are physician and physician are physician are physician are physician and physician are physician are physician are physician and physician are physici	dical Examiner	23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c	4.1	uence of):	er the mode of dy	ing, such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
P.O. Box 68	that the death certificated by the attending placed by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2□Feta nt at time of d	l death 3□	Ectopic pregnand Other (specify)	су			23	d. Date of delive	very Day Year
	w requires been sign should be	Completed by Ph	Part II. Other significant condit	•	th but not res	ulting in the ur	nderlying cause gi	ven in Part I		1	Yes 2	No 3 ☐ Pro	topsy findings available
Vital Re	Physician; The lav rthis certificate has ral director, page 2	Be	25. Was case referred to medic: examiner?	Hannital			0:		of Death	auto perfo 1⊟ Yes (Check only o	2 No	prior to c death? 1 □ Yes	ompletion of cause of
Division or Vital Records,	ding Ph J. After th funeral	Certification: To	3 Suicide 6 Could	28a. Date of (Month, itigation	Injury Day Year)	ER/Outpatien 28b. Time of Injury ome, farm, str	28c. Inju	ıry at ork?]Yes 2 □	No 2	8d. Describe	how injury		ral Route Number,
	To the Hospital or Attention within 24 hours after death To the Funeral Director completely filled to by the	Medical Cer	29a. Certifier 1 V Certifyi (Check only one) 2 Medica	ing Physician: To the bill Examiner: On the bas	is of examina	wledge, death ation and/or in	n occurred at the tvestigation, in my	time, date ar opinion, dea	nd place, a	nd due to the	cause(s) a , date and p	ind manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifit					se number)			signed (Month	8 / Z 00 8
R	-0		30. Name and address of person Dr. A Snyder	9901	Medica	al Cent	Print) ter Dr.	Rock	ville	e, MD	20850	0	
	Sta Registi		31. Date filed (Month, Day, Year APR 1 0 2008	32. Reg	istrar's Signa	are the							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician England** 11:05 P M Frances 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Carriage Hill Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 445-20-5315 27, 1924 Oklahoma Director Jan. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at DC 1 X Yes 2 No Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 4055 52nd Terrace NW 20016 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: ier than "natural", c t, the Merical Exan Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 7 tof Health and Mental Hygiene.
If item 27 is marked other than "n or other traumatic event. the Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ora Paul Fisher Nora Garret 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly E. McKee / Daughter 4055 52nd Terrace NW Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of Himportant: If ite any Injury or of 1 ☐ Burial 2 MCremation 3 ☐ Removal from State National Crematory 04/08/2008 4 ☐ Donation 5 ☐ Other (Specify) Falls Chuch, VA 21. Signature of Auneral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Respiratory Arrest 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Asthma 20 Years Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed 30 Years Chronic Obstructive Lung Disease attending physician and for use as the burial-tran Due to (or as a consequence of): death certificate be Physician/Medical as . IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 🛣 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 HNo 3 ☐ Probably 4 ☐ Unknown Right Cardiovascular Accident which caused Left Completed Hemiparesis - 3 Years 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page performed this certificate 2 **□**No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2KCKNo 1 | Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours after death.

To the Funeral Director: /

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

Division or Vital Records,

State Registrar

Medical

29a. Certifier

(Check cnly one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MD D0014107

April 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bryan Arling MD 2240 M Street NW Suite 817 Washington, DC 20037

31. Date filed (Month, Day, Year)

APR 09 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 4,2008 Year **Physician** Fernandez Antonia 1900 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2X F 66 5/04/1941 577-21-5343 E1Salvador Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 No Silver Spring MD Montgomery Director 10g. Citizen of What Country?
El Salvador 10e. Street and Number 10f. Zip Code "natural", or items 23a or 20902 1921 Alberti Drive permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must. once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2½ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1⊠Yes 2□No El Baltimore, Maryland 21215-0036 Specify: White Salvadoren Completed by 3 ☐ Widowed 4 A Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Francisco Chilagown Be Juana Fernandez ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Harris Way Galveston, Texas 77551 19a. Informant's Name/Relationship (Type. Print) Esmeralda Banda/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Municipal Cemetery
San Miguel 20c. Location - City or Town, State 20a. Method of Disposition San Miguel, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) El Salvador 21. Signatur of Funeral Service of PANTE TO Address RINALDI FUNERAL SERVICE, P.A. 9241 Columbia bLvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
Acute renal failure Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Cystogenic cirrhosis The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification: To After this nours after death.

neral Director: After this
filled in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D65305 April 7,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, Md 20910

DHMH 17 Rev 1/2001

State

Registrar

Nabila Khan M.D.

APR 09 2008

31. Date filed (Month, Day, Year)

34 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 = State Registra AMEND#23a(b)perMD4-10-08, EWW, Moob Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 7:20 a M **Physician** 04 2008 April Helen Finkelstein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Burtonsville Montgomery Holy Cross Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 R F Yrs 79 December 5, 1928 Poland Director 174-26-1525 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Silver Spring Director Montgomery **Maryland** 10g. Citizen of What Country? 10e. Street and Number 101. Zip Code Iteme 23a 20902 11104 Slye Court Completed by Funeral filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 x Married 6 Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dress Designer Clothing permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygier importent: if item 27 ie marked other th eny injury or other treumatic event, that once. 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freyda Oliner Henry Oliner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11104 Slye Court, Silver Spring, Maryland 20902 Martin Finkelstein - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 04/06/2008 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE Prysician /Medical Due to (or as a consequence of) Examiner METASTATIC Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? ŏ 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 3 Probably 4 DUAKnown ENous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an certificate 1 ☐ Yes 2 No Division of Vital or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 22 No # Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Tes 3□ DOA After thi 27. Mann f Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending 1 Natural 1 Yes 2 No within 24 hours efter death.

To the Funerel Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospitel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28595 Our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SmITH AVE, SUITE 203, AKH AMI, 2835 1 ASNEEM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 10 2008 Registrar

08-02998 Janice Feldman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar			Certifi	cate of	Death					eg. No.				
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		306 Carr Avenue							IC I I - d - a	0.41.1	0 Data of Pi		•		place (State or	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. last b	oirthday)	If Under	1 Year Days	If Under Hours	Min.				Foreign		
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and the File is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremat	ion 3 🗌 F	Removal from S	late	matory or oth				o. 1	22/2000		01-01	Max	ev1 and	
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier	g Physician:	To the best of	my knowledge	e, death occi	urred at the	time, da	ate and pl	ace, and	due to the c	ause(s) a	nd manne	er as stat	ted.	
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert Joseph Goldstein April 06 2008 10:12 aM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery 19449 Olney Mill Road 01ney 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director October 12, 1940 New Jersey 151-30-7180 67 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 X Yes 2 □ No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or a 19449 Olney Mill Road 20832 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 XYes 2 □ No If Yes, Give Year or Dates: 1964-1966 1 ☐ Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. n 27 is marked other than " r traumatic event ** Elementary/Secondary (0-12) College (1-4or 5+) Retail Operations Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Theodore Goldstein Judith Blumberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19449 Olney Mill Road, Olney, Maryland 20832 Susan D. Goldstein - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/2008 Fort Lincoln Crematory Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Non Small Cell Lung Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed the burial-tran Due to (or as a consequence of): OCIONAL MAIN RECORDS, P.O. Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 🛭 No Hospital or Attending Physician; rector, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🛮 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check onl) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signa ure and certifier 29c. License number 29d. Date signed (Month, Day, Year) D35635 April 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D., 18111 Prince Philip Drive, Olney, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar APR 0 9 2008

Physician /Medical Examiner

Funeral Director

iral", or items 23a or 28a-f show Examiner must be notified at "natural", or other traumatic event, the Medical permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any Injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760 cate has been signed by page 2 should be detact funeral director. To the Hospital or Attend within 24 hours after death To the Funeral Director:

Decedent's Name (First, Middle, Last)
Arturo 2. Date of Death 3. Time of Death GIRON April 7, 2008 9:20 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (II not institution, give street and number) 4c. County of Death 13620 Wendover Rd. Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 22, 1950 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Havana, Cuba 1**∭**M 2□F 58 152-38-8284 Usual Residence of Decedent 10c. City, Town or Location Silver Spring 10d. Inside City Limits 10a. State 10b. County Montgomery 1 ☐ Yes 2 No Director 10f. Zip Code 20904 10g. Citizen of What Country? 10e. Street and Number U.S.A. 13620 Wendover Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Special hite 1 ☐ Never Married 2 ☐ X Married 1 □XYes 2 □ No Specify: Cuban If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government Elementary/Secondary (0-12) Coilege (1-4or 5+) Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Maria Pintado Arturo Giron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13620 Wendover Rd., Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print) Debby Anker / spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from Statearden of Remembrance Apr. 10,2008 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Septice Licensee, 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophageal Cancer years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? /es 2 X No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Leon Hwang, MD

31. Date filed (Month, Day, Year)
APR 0 9 2008

To the Fune completely fi

1396 Piccard Drive, Rockville, MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D45880

April 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lou Ella Harkins 9:52 3, 2008 April Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10806 Brookes Reserve Road Upper Marlboro Prince George's 8. Date of Birth (Month, Day, Ye ugust 9, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year 1 ☐ M 2 😿 F 88 403-28-7557 1919 Director Kentucky August Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George's Upper Marlboro X□Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10806 Brookes Reserve Road Funeral 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc African 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify: American 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Bond Mary H. Gayle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derrick Harkins - Son 1213 Dale Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 April 2008 4 Donation 5 Dother (Specify) Lakeview Cemetery Cleveland, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions if any, leading to winned a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Diabetes Mellitus burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician requires that the death certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 🖸 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed at 2 should be d Completed by Atrial fibrillation 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 1□ Yes 2 X No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending (Month, Day Year) 1 X Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident the f Nithin 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined ö To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature Atitle of certifier

31. Date filed (Month, Day, Year)

APR 0 9

2008

address of person who completed cause of death (Item 23a) (Type, Print) Imelda Rodriguez-Miranda, M.D.

7611 South Osborne Rd. St. 106 Upper Marlboro, MD 20772

32. egistrar's Signature

29c. License number

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 04-05-2008 6:22 P M HARRY C. HILL 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL Prince George's Clinton
If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) Age (In yrs. last birthdav) (State or Foreign 8. Date of Birth (Month, Day, Year) Days 1**岔**M 2□F Months Wash.,DC 577-54-2407 69 07-05-1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ¥F¥Yes 2 □ No Maryland Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6311 Gredinger Drive 20735 U.S.A 14. Race - American I Black, White, etc. - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1965 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24E No Specify: 3 ☐ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Metro 12th +02 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus C. Hill Katherine Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11513 Cosca Park Place Clinton, MD 20735
ace of Disposition (Name of Date 20c. Location - City or Town, State Harry C. Hill, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 04-14-2008 Riverdlae Pk.Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland 22 Name and Address of Facility 21. Signature of Funeral Service Licensee May Hedgman M01374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myocald Due to (or as a consequence of): ABTERY OKONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILLIR 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe PERTENSION 2 1 No

Physician /Medical Examiner

Department of Important; If It any Injury or o

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

and: If Hear 27 is marked other than "natural", or Items 23a or 28a-1 show any or other traumatic event, Ite Medical Examiner must be notified at

altimore, Maryland 21215-0036

burial-tran physician as the attending | for use as been signed by the a should be detached page 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Examine Completed by Physician/Medical Be မ Medicai Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

26. Place of Death (Check only one)

28d. Describe how injury occurred

Clinton, Maryland 20735

25. Was case referred to medical examiner?
1 ▼Yes 2□ No

27. Manner of Death 5 Pending investigation

2008

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Road

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of cortifier

29a. Certifier

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

i 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

ddress of person who completed cause of death (Item 23a) (Type, Print)

JOPRIE, MD + 503 SUERA TO SUERA ITS

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh e880 6-18-08 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2008 VERMEL C. HARRISON APRIL 12:46 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY 5. Social Security 4/556 If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Months Days Hours 1 □ M 2 🕏 F APRIL 10 1938 MARYLAND 218-38-7552 69 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1√Yes 2□No Director MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 508 62nd PLACE # C 20743 USA or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any filury or other thaumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No BLACK 2 3 XWidowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) HOUSE WIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES R. MEDLEY IDA BELL ALLEN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS HARRISON JR./SON 508 62nd PLACE # C CAPITOL HEIGHTS, MARYLAND 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HARMONY CEMETERY 4/14/2008 LANDOVER, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME hack 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician pe Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q RESPIRATORY FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2X ER/Outpatient 3 □ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of ai or Attending P after death. 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State

31. Date filed (Month, Day, Year) APR 1 0 2008

29b. Signature and title of certific



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

DI6273

708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 06, 2008 Year **Physician** Carl Ivey 2:45 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4804 Wheeler Road Oxon Hill PG Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. †**∑** M 2□ F 09/04/1933 578-42-9159 74 **Director** N. Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1√Yes 2 No MD Oxon Hill Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4804 Wheeler Road 20745 U.S.A. Items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 49–72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black by 3 Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) oe filed with Elementary/Secondary (0-12) College (1-4or 5+) Master Sargent U.S. Army permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, til 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joe Willie Ivey Rosa Clay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Young – Son 10409 Blackstone Avenue; Cheltenham, Maryalind 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 04/12/2008 Brentwood, Maryland 5 Other (Specify) 4 ☐ Donation 22. Name and Address of Facility Freeman Funeral Services of uneral Service Lice 21, Signal 4594 Beech Road; Temple Hills, Maryland 20748 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ingicause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock Enter the disease, or con heart failure. List only Immediate Cause (Final Prostate Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) Examine sician and burial-transit certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for Month Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 ☐ Unknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Myelomorcytic Leukemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes ŽXNo director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: riding ! (Month, Day Year) 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Atter di within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

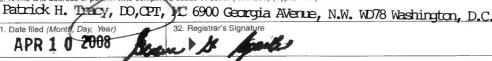
State Registrar

31. Date filed (Montal, Day, Year) APR 1 0 2008

29b. Signature and title

certifier

30. None and address of per who compl



d cause of death (Item 23a) (Type, Print)

29c. License number

CA# 057027

29d. Date signed (Month, Day, Year)

April 8, 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5^{Day} April The 1ma 2008ar Physician M. Johnson 3:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Pre Health & Rehab Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 X F Nov. 8, 1930 W. Virginia Director 577-50-6624 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Y Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20904 IISA 2601 Bel Pre Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No 1X Never Married 2 Married Specify: \$ 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Walker Johnson Mary Lou Thomas ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Shorter/ Daughter 13601 Sir Thomas Way#43, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 □ Cremation 3 □ Removal from State 4/11/08 Harmony Memorial Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McGuire Funeral Service, Inc. homa 1 7400 Georgia Ave, NW, Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Heart Disease months /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine The law requires that the death certificate be executed and buriaf-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2X No ed by the a 9□Unknown 9 Unknown page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsv performed? Yes 2 □ No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 🔲 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? s after death. il Director: After t Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 hours 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Suresh C. Gupta, M.D., 3503 Perry St., Mount Rainer, MD, 20712 31. Date filed (Month, Day, Year) APR 0 9 2008 3 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:20 PM 2008 April 6, Robert Leroy Jackson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Golden Living Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral Days Hours 1 XM 2 ☐ F 579-26-8882 81 August 1, 1926 North Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 United States 1708 Wheyfield Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 15 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Nidowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Contract Specialist 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Hubbard ၉ Monroe Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Son 1708 Wheyfield Drive Frederick, MD 21701 Robert L. Jackson, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1x Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemt. Apr 14, 2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home, Inc. 22. Name and Address of Facility 4001 Benning Road, NE Washington, DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Dementur YCARS **Physician** /Medical Examiner MONITHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral I 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0006 2223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANILTEN RELATION MD 196 TT DELVE, PREDCULE, TO 21703. 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State APR 1 0 2008 Registrar

			_ For	State of Ma		d / Depa	artment of H	lealth a					10017
		_	State Registrar			Cei	rtificate of I	Death			J. No. 🚄	UUO	10011
	Physicia	an	1. Decedent's Name (First, Middle,							Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Edward	L.	K	uff	4b. City, Town, or	Location of		pril	2, 4c. Cou	2008 nty of Death	5:00 A. M
	Examin	er	4a. Facility Name (If not institution, Suburban Hosp				Bethes		Death			ntgome	erv
	Funeral		.	6. Sex 7. Age	e (In yrs. le	ast birthday)	If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Birth			lace (State or Foreign
	Director		499-34-0576	1 🛣 M 2 🗆 F	83	Yrs.	Months Days	Hours	Min. Ju	(Month, Day, 1	1924		71and
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	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		3158 Gracefield	Road			209	04			U.	S. A.	
	ms 2%	Funeral	11. Marital Status	12 Was Decedent 8	Ever in U.S	6. 13.	Was Decedent of H If Yes, specify Cuba		in? (Specify	Yes or No-		Race - Americ	
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an	lid be lental rked o	To B	Samuel L. We	inberg				Rut	th Mor	vitz			
Maryland	shou and N s mal		19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Number	r or Rural R	oute Number,	City or To	wn, State, Zip	Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental lyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		Karen R. Kuff-D	emicco - Dg			Murray Hi						L3850
altimore,	Pages 1 nent of Hi int: If Iter iry or oth		20a. Method of Disposition 1 Derial 2 Cremation	3 Kemoval from State			osition (Name of matory or other place	ce)	Date 4/4/20	-		on - City or To	own, State
	t. Pag tmen tant:		4 □ Donation 5 □ Other (S _i		Na		1 Cremato						-
Ba	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service	Joensee 7			Banzansky						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
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	Examiner		O A Call Date and divine	a							5 Years		
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	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	uctive Pu	ctive Pulmonary Disease					15 Years			
90,	e be executed /sician and e burial-transit	ä											
687	icate physis	dic		d									
Box (Physician: The law requires that the death certificate it this certificate has been signed by the attending physral director, page 2 should be detached for use as the $0.4.62-0.8$	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	Date of deliv	rery
m.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnanc □ Other <i>(specify)</i> _	y 				Month	Day Year
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	aw requires that the despension of the a speen signed by the a should be detached to $\delta \delta c \omega$		Part II. Other significant condition			ulting in the u	underlying cause giv	ven in Part I.					the cause of death?
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Records,	has b	Completed by							_	24a. Was ar autops	y	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
	The icate by page 1, page									perform	_	1 ☐ Yes	2 No
Vita	ysiclan: The law is certificate has be director, page 2 s	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No		ant 2□	EB/Outpatie	ent 3 DOA Oti	205		Check onl∈ one 5 ☐ Reside		Other (Spec	i6d)
Division or	Physer this eral dii	<u>ان</u>	27. Manner of Death	28a. Date of Inju	ıry	28b. Time				d. Describe ho		- ' '	ny)
<u>o</u>	Attending r death.	ation	1 Natural 5 Pendin 2 Accident investi	g <i>(Month, Da</i> gation	ly rear)	Injury		Yes 2 1	No				
VIS	r Atte er deg irecto	Certification:	3 Suicide 6 Could i 4 Homicide determ				treet, factory, office		28f	. Location (St. City or Town	reet and N , State)	umber or Rui	ral Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. So the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifie		vui		29c. Licen	se number		2	d. Date s	igned (Month	, Day, Year)
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	1> 3		30. Name and address of person	who completed cause of	death (Item	1 23a) (Type		. 1 1 /			Taber	, _	
_	Ū			nington, M.	D. 10)215 F	ernwood F	Road,	Suite	100 A	Bet	hesda,	Md. 20817
		ate	31. Date filed (Month, Day, Year)	39 Registr	rar's Signa	ture	ant o						
	Regist	rar	APR 0 9	LUUD BEECK	0 0	S. F. S.							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
State
Registra MEND#23a(b/c)perMD4-9-08, BMW, Moto Certificate of Death 3. Time of Death 2. Date of Death Month **Physician** LIASNICK MACCIA 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Baltimore topkins Ito (pital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 10, 1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F NewYork, NewYork 057-26-2318 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2521 Tudo Court 21401 United States permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiens. I filem 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Education 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No White Completed by 3 Widowed * 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0.12) Deputy Chief Liquor Inspector Prince George's Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pincus Klein Adele Aptowitz မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Krasnick -husband 2521 Tudo Court Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 4/9/2008 Crownsville, Meryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA Donald U 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ali SLASE I'unal **Physician** lears disease or condition resulting in death) /Medical Due to (or as Lonsequence of): Examiner Abetes lass Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Hypertension Years Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: sa, vutcoms pl pregnancy 2 ☐ Fetal death 23d. Date of delivery 1 ☐Live birth 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been undrome 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 s autopsy performed 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DD66471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Room 8033, Baltimure 930 E. monument Kumar 31. Date filed (Month, Day, Year)
APR 0 9 2008 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 5^{pay} 2008^{ear} 4:30р м Bokman Kim Rita /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day 1 Years 8 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔼 F 80 224-11-8042 S.Korea Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Clarksville MD Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 6133 Rippling Waters Walk 21029 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Asian Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ki Kim Do Jun ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21029 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Oliver Kim/Son 6133 Rippling Waters Walk Clarksville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/08/2008 Silver Spring, Md Gate of Heaven 4 □ Donation 5 □ Other (Specify) 21. Signatur Puneral Service PATLIPADOS RINALDI FUNERAL SERVICE, P.A. Miles 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failur /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed End stage renal disease burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

APR 09 2008

30. Name and address of person who completed cause death (Item 23a) (Typ, Print)



D52261

April 5,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Milton A. Kibler 2008 April 7, 0300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F 577-24-8939 Director 85 April 22,1922 MD Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 No Director MD Prince George's Greenbelt 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 22 Ridge Rd. Apt.#224 20770 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🖾 No Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sales 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) James Kibler Dorothea Vorrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 22 Ridge Rd., Apt. #224, Greenbelt, MD 20770 Elizabeth A. Kibler/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 4/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. H. 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that dayset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepses hour /Medical Due to (or as a consequence of): **Examiner** Domentia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ arter desease 2 No 3 Probably 4 Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manur of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

31. Date filed (Month, Day, Year) State APR 1 0 2008 Registrar

29b. Signature and title of certifier

address of person who complet

ST. MARY'S HOSPITAL LEONARD TOWN JAMES DAMALOUT!. 32. Registrar's Signat

ed cadse of death (Item 23a) (Type, Print)

and manner stated

29c. License number

D>9821

29d. Date signed (Month, Day, Year)

20650

			For State Registrar	State of	f Maryla		artment of F		nd Mental H	1	008	Washington and the second	321
1. Decedent's Name (First, Middle, Last)					inodio or i	eath 3. Time of Death							
	Physici /Media		Shek Chan Lee	<u> </u>					Month April 7,	Day 2008	Year	4:40 a	М
100	Examiner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or	Location of		4c. County of Death					
أمم			18301 Georgia Aven	ıе , #406			01ney			Montgo	omery		
	Funeral			Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, L	ay, Year)	9. Birth	olace (State ontry)	or Foreign
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	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside C	ity Limits
	e Mar	Director	MD Montgome	ery		Olne	y					1 ☐ Yes	2 X No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cour	itry?	
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·~	ter de	Funeral	11. Marital Status1 ☐ Never Married 2 ☒ Married	12. Was Dece Armed For 1 ∐Yes	rces?	J.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origir n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	o- 14, R	ace - Amerio lack, White,		
21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exerciting in ust be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	re	1	□Yes 2√∏No	Specify:		Spec	cify: Asia	an	
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	and 2 s ealth ar n 27 is her trau		Koo Chun Lee / Wif						06, Olnev. M		n, state, zij	Code)	
ē,	the He		20a. Method of Disposition		20b.		sition (Name of place		Date Date	20c. Location	n - City or To	wn, State	
altimore,			N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		olale		ren Cemeters	i	12, 2008	Silver S	Sorina	MD	
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of):									
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٥	ertifica ing ph as th	Med	IF FEMALE:										
X R R	death certifi e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Feta	al death 3 🗆	Ectopic pregnancy				ate of delive		Va ==
	the a	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregn: 9 ☐ Unkno	ant at time of wn	death 5□	Other (specify)				/lonth	Day \	Year
7 .	that the ed by detac		Part II. Other significant conditions	contributing to de:	ath but not res	sulting in the un	derlying cause give	n in Part I	23e. Did	tobacco use co	ntribute to th	ne cause of d	leath?
SD	ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	d by				•	,g			Yes XX No		ably 4∐l	
cord	s beel shou	ete							24a. Was		Were auto	osy findings	availabla
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5	hysic his ce I direc	o B	examiner? 1 ⊟ Yes 2√√No	Hospital: 1 ☐ In	patient 2] ER/Outpatient	Other				ther (Specifi	/)	
<u> </u>	ing P	ü	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred										
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₹	or A	Certification: To	4 Homicide determined	28e. Place o	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, stre fy)	et, factory, office		28f. Location (City or To	Street and Num wn, State)	nber or Rura	Route Num	ber,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	edical	(Check only 2 Medical Exa	miner: On the ba	sis of examina	ation and/or inv	estigation, in my op	inion, death	occurred at the time,	date and place	, and due to	the cause(s	.)
	To th To th comp	ĕ	29b. Signature and title of certifier)		29c. License	number		29d. Date sign	ed (Month, I	Jay, Year)	
	1		Samuel	كلحر	1	mo.	D48152			April 7	, 2008		
	>		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type, P	rint)						
			Samuel Semegn, 12201	Plum Orch				20904					
	Stat Registra	٠	31. Date filed (Month, Day, Year) APR 1 0 20	US Julie	gistrar's Signa	ature Soci	M. O						
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			For State of Maryland State Registrar	Department of He Certificate of D		ntal Hygien Reg. N	2000 10	322
i e	Physici		. Decedent's Name (First, Middle, Last)		2	Date of Death	3. Time or	f Death
	/Medic Examin Funeral Director			4b. City, Town, or Solution School Sc	If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea.	c. County of Death)
	land		Jsual Residence of Decedent 10c. City, 0a. State 10b. County 10c. City,	, Town or Location			10d. Inside C	ity Limits
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	or 28%	Director	0e. Street and Number	10f. Zip Code		10g. C	itizen of What Country?	
	eath w	Funeral	1829 Buck Harbor Road 1. Marital Status 12. Was Decedent Ever in U.S	21851	snanic Origin? (Specif	v Yes or No-	USA 14. Race - American Indian,	
980	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 Married 3 Widowed 4 Divorced Year or Dates:	6. 13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 XNo	n, Mexican, Puerto Ric Specify:	ean, etc.)	Black, White, etc. Specify: white	
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SOF	be ev	To Be	Joseph Stanley Jackson		Eva Olivi		,	
Sack	s 1 and 2 should be if Health and Ments item 27 is marked other traumatic ev	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street a				
	and 2 lealth i		JoAnn Camden (niece)	1829 Buck Hart				
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Dani (Baltin		1	4 □ Donation 5 □ Other (<i>Specify</i>) 21. <u>Signature</u> of Furieral Service Licensee	son's Cemetery 22. Name and Address			Church, VA	
∞ 88	permit. Departr Imports any Inju		Mulay ADean	Holloway Fu	uneral Hom Ave., Poc	e, Protess omoke Cit	ional Association cy, MD 21851	
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68760,	be ex		Due to (or as a conseque	ence or).				
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.O. Box	The law requires that the death certifiate has been signed by the attending agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy			23d. Date of delivery Month Day	Year
rds, P	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resul	lting in the underlying cause give	n in Part I.		use contribute to the cause of a	death? Unknown
Division or Vital Records, P.O	rsician: The law re s certificate has bee lirector, page 2 sho	Completed				24a. Was an autopsy performed? 1 Yes 2 X	24b. Were autopsy findings prior to completion of death? 1 □ Yes 2 No	available ause of
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	l Othor	26. Place of Death (-		
P	Phys	- L	1 Inpatient 2 E	ER/Outpatient 3 DOA Othe	4 LI Nursing Home	5 ☐ Residence	6 ☐Other (Specify)	
ion	nding ath. r; Afte e fune	ation	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28b. Time of lnjury 28c. Injury Work 1 □ Y	? ∕es 2 □ No		-,,	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	me, farm, street, factory, office	28	Location (Street a City or Town, Sta	and Number or Rural Route Num te)	nber,
	e Hosp 124 hou e Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know Medical Examiner; On the basis of examination and manner stated.	vledge, death occurred at the tim ion and/or investigation, in my op	ne, date and place, an pinion, death occurred	d due to the cause at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
_	To th To th comp	Me	29b. Signature and tifle of certifier	29c. License			ate signed (Month, Day, Year)	
			1/8	200	058410	6	1/10/08	
_	BA 3		30. Name and address of person who completed cause of death (Item:	23a) (Type, Print)	O Anv I	737 (11)	(17) 6 7.1	702
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	23a) (Type, Print) WAR (S : U) P. ure	. , , , , ,	12 3/100	301.57	
	Registr	ar	ΔPR 1 1 2008	LINGATE!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** $\underline{\mathbf{A}}^{\mathsf{M}}$ April 8, 2008 7:05 Alma Fannie Lyons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Bel Pre Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2**X** F Yrs. Director 89 579-30-5548 Sept 17, 1918 Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at ↑Yes 2 No Directo Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6317 Morocco Street 20743 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Midowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Private 4.2 should be filed w h and Mental Hygiel Is marked other tl 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once. Betty Norwood - Niece 6317 Morocco St. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Apr 15, 2008 Landover, MD 4 Donation 5 ☐ Other (Specify) Harmony Mem. Park 22. Name and Address of Facility ture of Funeral Service Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Part Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Debility /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and ched for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Day 5 ☐ Other (specify) ∐Yes 2. XTNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lung Mass 1 🗌 Yes 2 No 3 Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA Certification: To 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 XNatural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Yea APR 1 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D56691

April 9, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:30 PM 04 2008 05 Lookenbill Teresa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cherry Lane Nursing Center Laurel 7. Age (In yrs. last birthday) er i s Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 □ M 2 🗗 F Director 204-18-5522 82 11/23/1925 Pennsylvania Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XIYes 2 □ No Director MD Prince Georges Laure1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or ury or other traumatic event, the Medical Examiner must be 9001 Cherry Lane 20708 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2₹ No 1 ☐ Yes 2 No Be Completed by Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Prince Georges County Area Agency on Aging 19a. Informant's Name/Relationship (Type. Print) Guardian of Person 6420 Allentown Road Camp Springs, MD 20748 Rosemary Mason/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, Riverdale Park Crem. 04/10/2008 Riverdale, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Montgomery-Cheatham Funeral Services Montgomery Cheatham Funeral 246 N. Washington Street Roseshock, or heart failure. List only one cause on each line. Rockville, MD 20850 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate outs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tra and Due to (or as a consequence of): physician the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1₺ Yes 2 No 3 Probably 4 Unknown COPD, Atrial Fibrillation, Anemia, Malnutrition, Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗌 No 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ∐ Yes 2🌠 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death 6 Could not be determined 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

State Registrar

Suite 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0.9 2008

Cherry Lane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Pritam S. Saini

211 Laurel, MD

D28998

20708

April 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8:00 A^M 4, 2008 <u>Apr</u>il Irene Leonardo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Calvert Manor Healthcare Center Rising Sun If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F July 14, 1931 Pennsylvania 172-24-2009 Director 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 1 XYes 2 ☐ No Director Rising Sun Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21911 104 Dotson Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: ģ White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Unknown ည Unknown Mieloch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 87 Ayers Drive, Rising Sun, Donna Brackett/Daughter MD 21911 4-8-2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ± <u>=</u> ; 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Department of Important: If any Injury of once. Rising Sun, Maryland T. Foard Funeral Home, P.A. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tra Due to (or as a consequence of) physician Physician/Medical attending p for use as use as IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Certification: To

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 n 24 hours after death.

In Funeral Director: A sletely filled in by the file completely within 24

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

							24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes □ No
25.	Was case referred to medic	al				26. Place of D	eath Check onl one	
	examiner? 1 Yes 2 No	Hospit	^{al:} 1 ☐ Inpatient 2 ☐]ER/Outpatient	3□ DO	A Other: 4 🛛 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
1	Manner of Death Natural 5 □ Pend 2 □ Accident inves		a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
	3 ☐ Suicide 6 ☐ Coul- 4 ☐ Homicide deter	d not be mined 28	e. Place of injury - At h building, etc. (Speci	ome, farm, stree	t, factory	, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29							ice, and due to the cause(s)	and manner as stated. d place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

29c. License number

1) 42800

1) South Union Avy

29d. Date signed (Month, Day, Year)

30. Name and address of person who complet

2008

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 13 Day 2008 Physician Dorothy Campbell Lewis 1939PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 128 Wilson Street Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-17-1933 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1□ M 2 1 F 220-32-7603 74 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Funeral Director Maryland | Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 128 Wilson Street 21078 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give ↔ Year or Dates 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 filed within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Pages 1 and 2 should be nent of Health and Mental ပ Frederick M. Campbell Alice Pearce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Lewis Hendricks (daughter) 629 Robinhood Rd., Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 4/15/2008 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the dise set of complications that caused the death Do not enter the mode of dying, such as conditions arrest, shock, or heart failure. List only one cause on each life. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 25 No 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient ၉ 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type (Print)

32. Registrar's Signature

DIMONE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month 04 20 Year 08 1650 М Edress Leyh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Allegany** WMHS Braddock Campus Cumberland 9. Birthplace (State or Foreign Country)

MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 30, 1925 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 M 2 X 212-24-2363 Director 82 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits works ! "natural", or Items 23a or 28a-f shov dical Examiner must be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 Wempe Drive 21502 USA 2 should be filed within 72 hours after death v and Mental Hygiene. Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. 3 3 XWidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Williams Beulah A. Smeltzer Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna Rock attorney 75 Greene Street Cumberland MD 21502 Health Item 27 I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If Iten
any injury or oth 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State 4/21/2008 Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donation 5 Dother (Specify) 21. Signature J Funeral Service Libens 22. Name and Address of Facility
Scarpelli Funeral Home. PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bladder Cancer Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 X No 1 Nnpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. Division or Vital Records, P.O.

or Attending within 24 hours after ucco...

To the Funeral Director: After the funeral by the funeral process. Hospital

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Ex Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130 Penn Avenue Cumberland Maryland 21502

Emmanuel Osei-Boamah MD

31. Date filed (Month, Day, Year) APR 2 4 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

Director

Funeral

Completed by

Be

Funeral Director

ns 23a or 28a-f show must be notified at "natural", or items 72 hours after is 1 and 2 should be filed within 72 hc of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical Pages 1 permit. Pages Department of Important: If Its any Injury or o

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

be executed

Box 68760.

P.0.

Division or Vital Records,

Examiner burial-tran physician Physician/Medical the use as attending ģ ed by the a detached f signed by t þ Completed After this certificate funeral director, Be Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🛣 F 075-14-2178 86 1921 New York Oct. 18, Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d, Inside City Limits 1X Yes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6111 Montrose Road 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Specify: 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Patraker Jennie Samuelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Bull - Daughter 18 Ridge Rd. Farmingdale, NY 11735 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 XI Removal from State National Crematory 4 Donation 5 Other (Specify) 4/8/2008 Falls Church, Virginia 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Lice 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30./Name and address of nerson who complete

Year)

09

DHMH 17 Rev 1/2001

32 Registrar's Signature

29c. License number D 35436

29d. Date signed (Month, Day, Year)

21 HONTROSERD, ROCKVILLEMP 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM/5, perfft (8/9,5/8/08, WS
State of Maryland / Department of Health and Mental Hygiene (1) (1) (2)

amend #1 Per PHY G913 3/21/2011 JH

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last)
Bernardina 2. Date of Death 3. Time of Death Zoog OBay Antonia Membreno 10101 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOS rom MOX JASHINGON MITTIN Micoma CUT (20 MEZ) Year If Under 24 Hrs. 5. Secial Security Number 219-45-376 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign El Salvador Date of Birth Days Months Hours 1 ☐ M 2 🔀 F 577971932 -45-3767 E1Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 Yes 2 No 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 20901 8857 Garland Avenue El Salvador 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Yes 2 No Sp Salvadoren Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jose Pablo Membreno Maria Juana Membreno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reyna Miriam Barrera/Daughter 4515 Matahala Drive Clinton, Md. 20735 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven 4/12/2008 Silver Spring, Md 4 ☐ Donation ,5 ☐ Other (Specify) 21. Signature et PHILIP TO THALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Arkensderon Concionation Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Johknown 1 TYes 2 No 3 Probably

. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical Examine

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

28a-f ahow

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"natural", or Items 23a

tiled within 72 hours after Hygiene.

permit. Pages 1 and 2 should be tiled within 7;
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "ns eny injury or other traumatic svent, the Medic 2002.

Baltimore, Maryland 21215-0036

The Medical Examiner must be notified at

Director

Funeral

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Completed

with the Maryland

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

scuarity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mon 1 ☐ Yes 2 ☐ Yo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to edical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 PFR/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide TCCrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 0 9 2008



S

30. Name a. v address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year April **Physician** Vera F. McGaha 7, 1:15A. M /Medical ^{4a} Facility Name (Knot institution, give street and number) Larkin Chase Nursing & Rehab. Ctr. 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 22, 1924 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 TF 230-24-4331 83 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Prince George's Greenbelt 1 X Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 22 Ridge Road, T7 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify Widowed 4 □ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Powell Fifer Julia Grim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
2C Plateau Place Greenbelt, Maryland 20/70 Karen F. Roberts -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metropolitan Crematory 4/7/2008 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licep Bonald V: Bofgwardt Funeral Home, PA Donald U 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the detached 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimers; Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an cate has autons certificate 2 X No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No director. Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4X1 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day 5 Pending investigation thours after death.

Inneral Director: A ely filled in by the fu death. 1 Tes 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

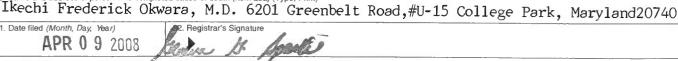
Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral I completely

> State Registrar

31. Date filed (Month, Day, Year)

(Check only one) 29b. Signature and title

APR 0 9 2008



completed cause of death (Item 23a) (Type, Print)

29c. License number

D43351

29d. Date signed (Month, Day, Year)

April 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jana H. Marney-Nelson Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Month Day April 6, 2008 Physician/ 1440 hrs Medical Examiner Jana H. Marney-Nelson c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Kensington 4016 Wexford Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) oreign **Funeral** Min. Hours Country) IN Director ct 22, 1927 307-26-8540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County illy 10a. State Yes 2 X No items 23a or 28a-f show ust be notified at once, Kensington MD hours after death with the Maryland Montgomery rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 迃 4016 Wexford Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married t. Pages 1 and 2 should be filed within 72 hours after death trnent of Health and Mental Hygiene.
rant: If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner must. ZXX No Yes Specify: White 1 Yes XX No specify: f Yes, Give Year Divorced Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Native American Contemporary Art 21215-0036 Fine Art Retail 5+ Gallery Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Wambaugh Be Ley Bernard Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 571 Meadow Sweet Circle, Osprey, FL 34229 Stephen C. Marney /Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Apr 9, 2008 Alexandria, VA Metropolitan Crematory Donation 5 Other Specify 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd W, Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death Modies a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) kaminer Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown ned by the detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? has 2 st No 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Nursing Home 5 Residence 6 Other: Scene Other, Hospital: 1 ER/Outpatient 3 DOA Inpatient 2 this 1 🗸 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27 Manner of Death Certification: Yes 2 No 1 V Natural Pending Director: 24 hours after death. Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined (Specify) To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD.

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

31. Date filed (Month, Day, Year)

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OCME

32. Restrar's Signature

Elias Martinez- Escobedo	State of Maryland / Department of Health

) PO 01 1 11111 111 210			
State of Maryland /	Department of He	ealth and Menta	al Hygiene

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		- For State Registrar Amend#6 . I	PerFHPGC4-1	0-08 Certific	cate of	Death				Reg. No.	L. U	00 10	
Physicia edical Exami	an/	1. Decedents Name (First, Midd	_{le,Last)} rtinez-Es						2. Date of I Month April 5,	2008	Year	3. Time of Death 0930 hrs	
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Funeral Director		5. Social Security Number None	6. Sex 7	. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hours		3/19	9. I 84 For	Birthplace (State or eigGuatema Country)	ıla
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locatio	on .						10d. Inside City	Limits
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he Maryland or 28a-f sho	Director	10e. Street and Number 4141 Ha	ague Ave			10f. Zip Co	ode 212	25		Gua	tem of What C temala	ountry? 3.	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers them 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medic A Examiner must be notified at once	Funeral		farried Armed For	dent Ever in U.S.	If Ye	Decedent es, specify (Cuban, M _ Gu	nic Ongin? Mexican, Pul latem specify:	(Specify Yes o erto Rican, etc. ala		White, etc.	nerican Indian, Black e (Hispan	
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5-0036 iled within 72 ho Hygiene. I other than "na he Medi. I Ex	Completed	Elementary/Secondary (0-12)		4 or 5+)		ree S	Serv	rice			Servi	ce	
21215-003 ould be filed within I Mental Hygiene. 5 marked other th ic event, the Medi	Be Co	17. Father's Name (First, Middle Jose Gui	llermo Es	cobedo	Del	Cid	18 E	Mothers N Patro	ame (First, Mid Cinia	Mart	inez	Rosales	
and 2 should I tealth and Mer tem 27 is man traumatic even	0	19a. Informant's Name/Relation Felipe Nery	ship (Type, Print) Escobedo (or Rural Route Pe Ball				
S I S		20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other 5		m State Ceme	e of Disposi	tion (Name ler Hace)	of ceme era	tery, L 04	Date 1/15/20			or Town, State ala	
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of Vital Records, P.O. Box 68760, ag Physician: The law requires that the death certificate be extent this certificate has been signed by the attending physician rearl director, page 2 should be detached for use as the burial	in/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		outcome of pregnandirth	cy 2 Fe	tal death	3	Ectopic pr	regnancy	23	d. Date of deli Month	ivery Day Ye	аг
Box 687 e death certifi the attending ed for use as t	ysiciar		nknown g Unkno	ant at time of death	5 Ot	her (Specii	fy)			-			- 1
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rds, l requires been sig	Completed									Was an autopsy		e autopsy findings a r to completion of car	
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Fital Rec sician: The is certificate lirector, page	Be	25. Was case referred to medic examiner?		npatient 2 🗸 ER	VOutpatient		10	thor:	Nursing Home	5 Resid	ence 6 0	Other:	
	tion: To		28a. Date (Month Apr 5, 20	of Injury 28	Bb. Time of I 830 hrs	njury 28		at Work?	Tree fo	cribe how in	jury occurred ubject		
Division Attents after decreased in Director Illed in by t	Certification:	3 Suicide 6 Co	vestigation uld not be termined (Specify)	e of Injury - At home	e, farm, stre	et, factory,	office bu	ilding, etc.	28f. Loca or To 318 Hari	tion (Street own, State) em lane, C	and Number o	or Rural Route Numb Md.	er, City
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director / completely filed in by the R	Medical C	29a. Certifier 1 Certifying	Physician: To the bes	of examination and/	death occur or investiga	rred at the t	time, dat opinion,	e and place death occu	e, and due to the	e cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
2 × 3 × 3	₹	29b. Signature and title of certi		tateu.		29c.	License O.C.M	number		- 1	Date signed	(Month, Day, Year)	
		30. Name and address of person	on who completed caus	se of death (Item 23			100				0, 2000		
4 31	State	Margarita Korell MD 31. Date filed (Month, Day, Yea	r) 🕒 32. Re	dical Examiner	111 P	enn Stre	eet, Ba	Itimore,	MD 21201				
Regi		4 5 5 4 6 7600	Keen	1 Apr	all!						,		
DHMH 17 Rev 1	/2001			•	ORIGINA	NL							

Physic /Medi Exami

Funeral Director

	State of Maryland / State of Maryland / Registrar	•	ırtment <i>tificate</i>			nd Me	ntal Hy	giene Reg. No.	711	18	13333
9	Decedent's Name (First, Middle, Last)		imoure			2.	Date of De				3. Time of Death
ian	Juana Middleton						Month April	Day	2008 Y	'ear	6:04 A M
cal ner	4a. Facility Name (If not institution, give street and number)		4b. Citv. T	Town, or I	_ocation of		Whiti		County of	Death	0.04 A
iei	Washington Adventist Hospital		Tako								57
	5. Social Security Number 6. Sex 7. Age (In yrs. last the	birthday)	If Under	1 Year	If Under 2	4 Hrs. 8.	Date of Bir	Montgomery Birth 9 Birthplace (S			y lace (State or Foreig
	578-70-3310 1□M 2ૐF 56	Yrs.	Months	Days	Hours	Min.	(Month, Da		_	Cour	try)
	Usual Residence of Decedent						Jan I,	17.)	Nasii	ington, D
	10a. State 10b. County 10c. City, To	wn or Lo	cation						_	1	0d. Inside City Limits
ţ	District of Columbia Was	hing	ton							1 X Yes 2 □ No	
ie	10e. Street and Number	HTILE	10f. Zip	Code				10g. Citi	at Cour	try?	
0 0	4418 Falls Terrace, SE #2		200	119				Uni	ted S	Stat	es
Completed by Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decede f Yes, speci		panic Origi	in? (Specif	y Yes or No		14. Race -	Americ	an Indian,
T	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		_	_		Puerto Rio	an, etc.)			White,	
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	'	i□Yes 2	XI NO	Specify:				Specify:	BT	ack
ted	15. Decedent's Education (Specify only highest grade completed)	a. Deced	lent's Usual kind of worl	Occupa	tion	of working		16b. K	ind of Busi	ness/Inc	dustry
Jp.	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use	e retired)	anig most	or working					
등	12 years	Hou	se Ke	eper				Pr	ivate	2	
Be (17. Father's Name (First, Middle, Last)				18. Mother	's Name <i>(F</i>	irst, Middle	, Maiden	Surname)		
2	Jerome Middleton				Edit	h Far	thing	3			
			g Address								*
	Kenneth Williams - Husband 4	418	Falls	Ter	race,	SE #	[‡] 2 Was	shine	gton,	DC	20019
	20a. Method of Disposition 20b. Place ceme	of Dispos	sition (Nam	ne of ther place)	Date	•	20c. Le	ocation - C	ity or To	wn, State
	1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's	Cre	mator	У	4.	-15-0	8		Clint	ton,	MD
	21. Signature of Funeral Service Licensee		. Name and					uner	al Ho	ome,	Inc.
	1 Horney Wand	4	001 B	enni	ng Ro	ad, N	NE Was	hing	ton,	DC	20019
	23a. Part1. Exter the disease, or complications that caused the death. Di shock, or heart failure. List only one cause on each line.	o not ent	er the mode	e of dying	, such as c	ardiac or r	espiratory a	arrest,			Approximate Interval Between
	Immediate Cause (Final	. (MRS	1						1	Onset and Death
	disease or condition resulting in death) a. Due to (or as a consequence	e of):		_	,					-	
	END STAC	RE	126	SNA	H	DIG	EAS	E.			
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):								1	
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	.7	ME	CCC	100	*					
Exa	resulting in death) Last Due to (or as a consequence			,							
dical Examiner	La HYPEYCTE	201	101)							
			_			-					
N/U	IF FEMALE: 23b. Was decedent pregnant in the cost 10 program 2 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea]						23d. Date	of delive	ery
icia	1 Ves 2 No 4 Pregnant at time of death		Ectopic pre Other (spe						Mont	h	Day Year
hys	9 ☐ Unknown 9 ☐ Unknown										
by Physician/Me	Part II. Other significant conditions contributing to death but not resulting	j in the ur	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contrib	ute to tl	ne cause of death?
D D	MALNUTRITION.						1 🗆	Yes 2	12 140 3	☐ Prob	ably 4 Unknow
Completed							24a. Was	an	24b. W	ere auto	psy findings available
E C								ormed?	pri de	or to co ath?	mpletion of cause of
	25. Was case referred to medical				26 Place	of Doath //	1□ Yes Check only	2 100	5 1L	Yes	212 No
To Be	examiner? 1 Yes 2 10 10 Hospital: 1 10 Inpatient 2 ER/0	Outpatien	t 3 □ DO.	Otho	r.		5 ☐ Res		€ □Othor	(Cnooii	
T.	27. Manner of Death 28a. Date of Injury 28b	. Time of		8c. Injury Work			d. Describe				<u>y)</u>
ţ	1 12 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	М		? es 2□N	lo					
fica	3 Suicide 6 Could not be 28e, Place of injury - At home.	farm, str	eet, factory	, office		281	. Location	(Street ar	nd Number	or Rura	I Route Number,
erti	4 ☐ Homicide determined building, etc. (Specify)						City or To	wn, State	e)		
alc	29a. Certifier 'E' Certifying Physician: To the best of my knowled	lge, death	n occurred a	at the tim	e, date and	place, an	d due to the	e cause(s) and man	ner as s	tated.
Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or in	vestigation,	, in m y op	inion, deat	h occurred	at the time	, date an	d place, ar	nd due t	o the cause(s)
Me											
	> Styrmin, MD		1,	7-2	928	4		41	5/2	009	7
	20. Name and address of person who completed equal of death (Itam 93s	a) (Type.	Print)								^
	SHAUD SUMMIM, MD, WASH	HNG	TON	MADI	IEMI	57 1	tosp.	TA	Lom	MA I	20912.
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	_ صرد	-						N	(D-	20912
rar	APR 0 9 2008 Read A	W									

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 April 05, **Physician** Belaynesh Mekriya 4:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab. Nursing Center Montgomery Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F Months 64 Director 215-19-2988 09-11-1943 Ethiopia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 1921 Merrifields Drive death v Ethiopia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "netural', Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4th Housewife Self- Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 ie markad othing eny injury or other treumetic event ORE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mekriva T. Giorgis Wudnesh Tessma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aynalem Gidey (Daughter) 1921 Merrifields Drive Silver Spring MD 20906 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Family Cemetery 04-10-08 Addis Ababa, Ethiopia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. nda C 361 Jacon 3447 14th St. N.W. Washington Dc 20010. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic esophageal cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ The law requires that signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy certificate 2X No 1 Yes of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours are within 24 hours are Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0054566 8/08. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Army # 1-17 Silverspring MD2090 Sunitha Bhogavilli 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 9 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene. \cup \cup \cup Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 8:50 A M John Paul Marino /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Atlantic General Hospital Berlin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day, Young) | Min. | 5/7/1945 Birthplace (State or Foreign Country) 6. Sex **X** M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 577-60-8076 62 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2X No **Funeral Director** Bishopville Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21813 USA 12239 St. Martins Neck Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other eny injury or other treumetic event 9088. 17. Father's Name (First, Middle, Last) Sue Theresa Daly Paul William Marino ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Brenda Marino / wife 12239 St. Martins Neck Rd., Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 4/14/2008 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) REWAL Physician STAGE EWD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown DIABETES Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 1 ☐ Yes 2 ☐ No Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 300A 2 ER/Outpatient To the Hospital or Attending Phys within 24 hours after death.
To the Funerel Director: After this a completely filled in by the funeral dir o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27993 4-9-09 waters 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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DeD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Month **Physician** 01:55 AM Roy Davis Mentzer April 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Yrs. 216-05-3737 87 1920 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No Maryland Director Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 106 Weber Street U.S.A. 21078 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No tr Yes, Give Year or Dates: 1 Never Married 2 Married 1942 Specify: White 1 ☐ Yes 2 No Specify Š 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Administrator Civil Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event pope. John Clarence Mentzer Clara Lillian Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean E. Mentzer (Spouse) 106 Weber Street, Havre de Grace, Maryland 21078 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 04/09/2008 Haure de Grace, MD 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Lices 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Physician Severe Hynoxaemia. /Medical Examiner Distuse ful monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ysicien and e burial-transit Aurtic stenosis Due to (or as a consequence of) **6**. Box 68760 1040 Physician/Medical anding physical use as the l IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 ☐ Yes 2 ☐ No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28b. Time of Injury 27. Manner of Death ate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Mospital or Attending Pl 24 hours after death. Funeral Director: After I 1 Naturat 5 Pending 1 🗌 Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Host within 24 ho To the Func (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 29c. License number B. Parekh MD D0018424 April-6-2008

State Registrar B. D. Pare Kh M 9
31. Date filed (Month, Day, Year)

APR 2 4 2008

30. Name and address of pereon who completed cause of death (Item 23a) (Type, Print)

1908



ORIGINAL

Harford

MD 21047.

fallston

Road.

Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicial /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

lotl Regi

	٠.	For State Registrar		State of Ma	aryland /			of Health of Deati		/lental H	ygien Reg. N	6 U	08	13	337
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icia		Edgar M	arino							Month April		^{ay} 2008	Year	0.00	9 P M
díca nine	-46			e street and number)			4b. City. To	own, or Location	n of Death	APLII		c. County	of Deat		9 F
IIIIe	# 1		ss Hospit									•			
al		5. Social Security N			je (In yrs. last b	oirthday)	If Under 1		er 24 Hrs.	8. Date of E	Birth	lontg	Birtl	hplace (State of	or Foreian
or		219-54-7	936	MM 2□F	60	Yrs.	Months I	Days Hours		(Month, L		947	Co	ombia	
		Usual Residence of			00					MOV. I	J 9 1	. 747	COI	Ollibra	
		10a. State	10b. County		10c. City, To	wn or Lo	cation							10d. inside C	ity Limits
	핝	MD	Montgome	rv	Montgo	mers	7 Vill:	30e						1 ☐ Yes	2 ₹No
	ire	10e. Street and Nur			121011080	mer,	10f. Zip C				10g. C	citizen of V	Vhat Co	ountry?	
	<u>=</u>	9902 Wall	ker House	Road #5			2088	36			USA				
	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		13.		nt of Hispanic C y Cuban, Mexic	Origin? (Sp	ecify Yes or N	-	14. Rac		rican Indian,	
ı	교	1 X Never Marr	ied 2□ Married	1 Yes 2	No					nican, etc.)			k, White	e, etc.	
	<u>چ</u>	3 Widowed	4 Divorced	1 K] Yes 2 If Yes, Give Year or Dates:	1971-75		1 X Yes 2	□ No <i>Spe</i> cii		mbian		Specify	Whi	.te	
	Completed	(Spec	15. Decedent's Ed	ducation		a. Dece	dent's Usual	Occupation done during m	ost of work	dina .	16b.	Kind of Bu	usiness/	Industry	
1	ם	Elementary/Seco		College (1-4or 5	5+)	life.	DO NOT use	retired)							
	ဂွ် 			4	A	ccou	ıntant					tel.			
	8		(First, Middle, Last)					18. Mot	her's Nam	e (First, Midd	le, Maide	en Surnan	ne)		
,	၉	J. Robert	to Marino						s Sol						
			ame/Relationship (Street and Num							
		Maria Ine	es Barbos	a/sister				Lawn Ro	ad Si	lver S	prin	g, MI	20	904	
		20a. Method of Disp		Removai from State	20b. Place ceme	of Dispo tery, cre	sition (Name matory or oth	of erplace)		Date	20c.	Location -	City or	Town, State	
			5 Other (Specif		Chesa	peak	e Cren	natory	04/1	0/08	Be1	tsvil	lle,	MD	
ouce.		21. Signature of Fu	neral Service Licer	iseey / /		C 0	2. Name and	Address of Fac ome Cres	ility	n Com-		D 0	n	70/	
9		Flu	enty I	Heuth	MO125										21020
		23a. Part1. Enter t	he disease, or com	plications that caused one cause on each li	the death. Do	not en	ter the mode	of dying, such	as cardiac	or respiratory	arrest,	arks	/ T T	Approximation Interval Bet	te tween
n		Immediate Cause ((Final	_a Pulmonar		rton	cion							Onset and	
al	1	resulting in death)			a consequence		SIOII			-					
r				b Septic S	Shock										
_	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate	Due to (or as	a consequence	e of):									
	Examiner	Cause (Disease or that initiated events	injury	Acute Re	enal Fa	ilur	e								
	ŭ	resulting in death) I	Last	Due to (or as	a consequence	e of):									
	edical		•	d. Cellulit	is										
	Physician/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome		+h 2F	TEatonia proc	an an au			i	23d. Da	te of del	livery	
		in the past 12 1 ☐ Yes 2 [4☐Pregnant a			∃Ectopic preo ∃Other <i>(spec</i>					Mo	πth	Day	Year
Ι.	hys	9 ☐ Unknown		9□Unknown											
	by P	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting	in the u	nderlying cau	ise given in Par	t I.	23e. Did	tobacco	use cont	ribute to	the cause of	death?
	be	Chronic A	trial Fil	brillation	1					1 [Yes	2□ No	3 □ Pr	robably 4 🔀	Unknown
	Completed	Allergic	Dermetit:	is						24a. Wa		24b.	Were au	utopsy findings	available
	E O	Tracheiti								pe	topsy formed?		prior to death?	completion of c	ause of
		25. Was case refer						26 Pla	re of Deat	1 Yes th (Check only		NO	1 ☐ Yes	2□No	
	To Be	examiner? 1 ☐ Yes 2 🛣	(No	Hospital: 1 X Inpatie	ent 2 ER/C	Outnatie	nt 3 DOA	Other:		ome 5 ☐ Re		s □Oth	or (Cno	oi64)	
		27. Manner of Deat	th	28a. Date of Inju	ıry 28b	. Time o		c. Injury at Work?	runaing ric	28d. Describ				GHY)	
	tio	1 XNatural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury	M	Work? 1 ☐ Yes 2	□No						
;	Tica	3 ☐ Suicide	6 Could not be determined	28e. Place of Inj	ury - At home,	farm, st	eet, factory,	office		28f. Location	(Street	and Numb	er or Ru	ural Route Nun	nber,
	ert	4 ☐ Homicide		building, et	tc. (Specify)					City or T	own, Sta	ate)			
	Medical Certification:	29a. Certifier	1 X Certifying Ph	nysician: To the best	of my knowled	ge, deat	h occurred at	the time, date	and place,	, and due to th	ne cause	(s) and ma	anner as	s stated.	
:	g	(Check only one)	2 Medical Exar	niner: On the basis of and manner st	of examination a ated.	and/or ir	ivestigation, i	n my opinion, c	leath occur	rred at the tim	e, date a	and place,	and due	e to the cause(s)
:	ž	29b. Signature and	itte of certifier	1			29c. I	License numbe	r		29d. E	ate signe	d (Mont	h, Day, Year)	
) ((Ano/1				N.	55148			Apı	ril 9	, 20	800	
		30. Name and addr	ress of person who	completed cause of c	leath (item 23a) (Type,		00.10			I				
)		DELIOY	ANGLIN		150			Glen	Rd :	Silver	Spa	na n	10	20910	
Stat	е	31. Date filed (Mon			ar's Signature		4		*	, 0,1	7	-			
stra	ır		APR 1 0 2	2008 June	ue &	1	(dead)								

3. Time of Death

Day

Physician /Medical **Examiner**

Funeral

Director

with the Maryland 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at death v e filed within 72 hours after all Hygiene.

other than "natural", or iter Pages 1 and 2 should be t ment of Health and Mental I of Health and Menta item 27 Is marked permit. Pages Department of Important: If it any Injury or or

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

law requires that the death certificate be executed sician and burial-trans the attending for use as SS detached the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

6 2008 7:00 A 4c. County of Death PRINCE GEORGE'S 1209 CRISFIELD DRIVE OXON HILL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖫 F 88 578-22-9229 1919 10 - 8 -NORTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 X Yes 2 No Directo PRINCE GEORGE'S OXONHILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20745 1209 CRISFIELD DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married BLACK 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY SOLOMON WILLIE NIXON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 CRISFIELD DRIVE OXONHILL, MARYLAND 20745 DIANNE BELT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 4/11/2008 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√ No 24a. Was an autopsy performed 2**▼** No **¾**□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 9, 2008 D19431 30. Name and address of person Nilo completed cause of death (Item 23a) (Type, Print) Frank Ryan M.D. 11701 Livingston Rd Suite 103 Ft. Washington, Maryland 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 1 0 2008

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** April 7, 2008 4c. County of Death Carolyn Marie Perry /Medical 3:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 ☐ F 227-72-7082 Director 58 Jun 1, 1949 1/A Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hyglene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ¾∏ No Director Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18210 Swiss Circle 20874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1, Yes 2 No
If Yes, Give
Year or Dates: 1970-7 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administration Clerk/Business Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I of Health and Menta Item 27 is marked 2 Edward Allen Patterson Helen Irene Randolph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claude Edward Perry, Jr. /Husband 18210 Swiss Circle, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Apr 11, 2008 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examiner that initiated events resulting in death) Last and burial-tra Due to o as a consequence of): UNIC Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No the detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 3 Bunknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 → R/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After i 1XX Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: To the Hospital or Attending

Baltimore, Maryland 21215-0036

hours after death uneral Director: filled in by

within 24 hours a To the Funeral C ompletely (VP

Nicole Vetere

29b. Signature and title of certifier

4 ☐ Homicide

(Check only

29a. Certifier

and manner stated.

29c. License number 10064079

1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, MD 20850

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 09



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lucile P April 9, 2008 5.30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner National Lutheran Home Montgomery Rockville Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🔯 F Director 240-05-2995 NC Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show must be notified at 1 Yes 2XXNo Director Wheaton Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code Iteme 23a 2309 Hermitage Avenue 20902 USA Funerai ges 1 and 2 should be filed within 72 hours after death it of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Iteme 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20X No Specify White Specify: Yes Give Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert W. Punch Laura E. Frye 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2309 Hermitage Avenue, Wheaton, MD 20902 Adrian S. Propst Sr. / Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or otl 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Apr 12, 2008 Rockville, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Onsal and Death 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical and to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IE FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ete has been signed by the inpage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed 1 Yes 2 No 1 Yes 2 1No I or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 2 No 1 🗌 Yes investigation 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number enevi

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

APR

10

Charles W. Karesh 26033 Ridge Road, Damascus, MD 20872

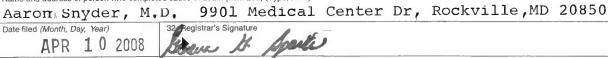
Registrar's Signature

			For State Registrar	State of Ma	ryland		artment of trificate of	Health and I	Mental Hy	giene Reg. No	7111	8 1	334
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ALICE F.	PAYTON						L 7,	, 2008	8 6:	me of Death
)	Examin	er	4a. Facility Name (If not institution, give st Shady Grove Adv 5. Social Security Number 6. Sex	entist 1		ital	•	or Location of Death CKVille If Under 24 Hrs.	8 Date of Bi	rth	MONT(GOMER'	Y State or Foreign
	Funeral Director			M 2 1 F	60	Yrs.	Months Days		(Month, D	, 194 , 194		Country)	rolina
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	ctor	10a. State 10b. County MD Montgom	ery	10c. City,	Town or Lo Ge 1	rmantow	'n		10.00		M	ide City Limits]Yes 2 ☐ No
	vith th	Ö	10e. Street and Number				10f. Zip Code	07.4		Tog. Cit	izen of What		
	s 23g	ra	19729 Crystal	ROCK Dr 2. Was Decedent E			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Black, N						an
020	urs after de al', or item Examiner n	by Funeral Director	11. Marital Status 1. Marital Status 1. Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Tyes 1 N If Yes, Give Year or Dates:			rvas Decedent of f Yes, specify Cu 1 ☐ Yes 2 🙀 No		o Rican, etc.)	Black, White, e			ari,
0-017	vithin 72 hor ne. han "natur e Medical E	Completed	15. Decedent's Educi (Specify only highest grade	de completed) (Give kind life. DO N			kind of work done DO NOT use retir	t's Usual Occupation d of work done during most of working NOT use retired) COMET SETVICE			16b. Kind of Business/Ind		Bank
שוות ע	should be filed withi and Mental Hygiene. s marked other thar umatic event, the M	Be	11th 17. Father's Name (First, Middle, Last) James Payton				18. Mother's Name (First, Middle, M Letha Evans				Maiden Surname)		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Name/Relationship (Type Barry Payton (,				et and Number or Ru Avenue	ural Route Num	ber, City			
ָב בי			20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State	cei	metery, cirei	sition (Name of matory or other pl		Date 4/U8		ocation - City		
Dalli	permit. P Departme Important any Injury		4 □ Donation 5 □ Other (Specify) 2 ign lun uneral Service) ins	Munt	leur	1 22	2. Name and Add	ress of Facility SI	NOWDEN	FUN	VERAL	HOME	P.A
ŀ			23a. Part1. Enter the disease or complic shock, or heart failure. List only one	ations that caused e cause on each lin	the death.	Do not ent	er the mode of dy	ring, such as cardia	c or respiratory	arrest,		Interv	eximate al Between t and Death
	Physician /Medical		immediate Cau ⁴ e (Final disease or condition resulting in death)	Due to (or as a									mes
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classass or injury that initiated events c.	Due to (or as a	a conseque	ence of):							
0,00,	ate be executed hysician and the burial-transit	dical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):							
O. DOX O	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan	ісу			23d. Date of Month	delivery Day	Year
cords, r	luires that n signed b ld be deta	by	Part II. Other significant conditions com		it not resuf	ting in the u	nderlying cause g	liven in Part I.			use contribut		se of death?
222	he law rec e has beer ige 2 shou	Completed	Disbets mel	lit's					per	opsy formed?	prior deat	to completion	dings available on of cause of
N I G	iffication, pa	e C	25. Was case referred to medical					26. Place of Dea	1 Yes		0 1	Yes 2□N	0
	Physiclan: r this certifica ral director, I	0 8	eyaminer?	ospital:	nt 2 🗗	R/Outpatier	nt 3 DOA	41	lome 5□Re		6 □Other (Specify)	
	5 9 9	ation: T	27. Manner Death 1	28a. Date of Injur (Month, Day	у	28b. Time o Injury	f 28c. Inj		28d. Describe			, , , , ,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fig. 1) City or Town, State)							r Rural Rout	e Number,		
	he Hospii in 24 hour he Funera pletely fillk	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir		examinati								ause(s)
	Vith To t	Ž	29b. Signature and title of certifier	'~ M.N				59129		29d. Da	ate signed (M	. 1	'ear)
	0/		Mr. sular	- /	,			2 11		İ	710	. 103	

State Registrar

31. Date filed (Month, Day, Year) APR 1 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8 2008 ear APRIL 9:35 A M POWELL DANIEL 4c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**₺** M 2□ F 70 MAY 27 1937 10c. City, Town or Location 10b. County

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must han marked. Baltimore, Maryland 21215-0036

Physician

Physician /Medical Examiner

The law requires that the death certificate be executed and burial-trai attending physician the use the signed by should be peen has page 2 certificate or Attending Physician; this funeral After filled in by the Director

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral t Registrar

/Medical 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL Birthplace (State or Foreign
Country) 5. Social Security Number PITTSBURG, PA 211-30-3572 Usual Residence of Decedent 10d. Inside City Limits 1 TXYes 2 TNo MD PRINCE GEORGE'S LANHAM Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code USA 20706 5513 CORDONA STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Affice of the state of the sta 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo BLACK Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT POSTAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLE ROSE JACKSON HANDSOME POWELL ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 CORDONA STREET LANHAM, MARYLAND 20706 DOLLEAN A. POWELL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 4/16/2008 CHELTENHAM, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nouthr disease or condition resulting in death) METALTATIC PARCLEAC Due to (or as a consequence of): Sequentially list conditions, if any local representation of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) S No 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Axaminer: On the basis of examination and/or investigation in my original death accurred. 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa and_title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 MUMPOLI J. Fellum Richard mo 32. Registrar's Signat 31. Date filed (Month, Day, Year) State APR 1 0 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31 **Physician** Annie Margaret Price 2008 9:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kensington Nursing Center Kensington Mantgarery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 257 F Days Hours 239-38-6750 Director 11/17/1928 South Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "netural", or items 23e or 28e-f show other treumatic event. The Modical Examinar must be notified at 1 Nes 2 No MD Montgomery Director Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 North McCommas Avenue 20895 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "netural", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintance Engineer Federal Covernment 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James B. Wallace Eunice Brunson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s if Health an item 27 is i Barbara Salley - Niece 609 Hathaway Court; Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 4/8/2008 Washington, D.C. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services Funeral Fryice L 21. Sign to 4594 Beech Road; Temple Hills, Maryland 20748 Part1. Enter the disease, or comp shock, sheart failure. List only of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician with Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? deprision 24a. Was an autopsy performed? res 2 No 2 No 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient After thi 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 143121 Chow dus 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) 15216 DINO DRIVE : AURTONSVILLE, MD 20 866 CHOWDHURY, MD; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Sig

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		•	For State Registrar		State o	of Marylar		artment rtificate		ealth and N eath		giene, Reg. No.	2008	133	45
ı	Physicia	an	1. Decedent's Nam	e (First, Middle	e, Last)						2. Date of De Month	ath Day	Year	3. Time of D	
	/Medic			arlene R				45 075 7	Farrier and	ocation of Death	April 4,		County of Death	4:55 p	M
	Examin	er			n, give street and nu	imber)				ocation of Death		101	topmery		
	Funeral		5. Social Security N	meridge A	6. Sex	7. Age (In yrs	. last birthday)	Whea If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or i	Foreign
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	and		Usual Residence o 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	cation				·		10d. Inside City	Limits
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	r 28a	Director	10e. Street and Nu					10f. Zip	Code			10g. Citiz	zen of What Cou	ntry?	
	h with	al D	2802 Blu	eridge A	venue				20902			USA			
2-003p	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show Geal Exhibition in 181 be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		12. Was Dec Armed F ied 1 □ Yes If Yes, G Year or I	edent Ever in U orces? 2 🔁 No ive Dates:		Was Deced If Yes, spec 1 □Yes 2		panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		14. Race - Ameri Black, White, Specify: Whit	etc.	
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7	filed within Hygiene. other than "		12		1		Homen	naker		8. Mother's Nam	- /Eirot Middle	L	Home Surnama)	<u> </u>	
and	be fil ntal H ed ott	Be	17. Father's Name Phillip St		Last)				'	Myrtle Ni		, ivialuen	Surname)		
Š	hould nd Me mark matic	ဥ	19a. Informant's N		hin (Type Print)		19b. Mailir	na Address	(Street ar		<u>-</u>	er, City o	r Town, State, Zi	p Code)	
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timore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, I'm. Aonce.				3 ☐ Removal from	State 20b.	Place of Dispo cemetery, crer	sition (Nam natory or ot	ne of ther place)	i	Date		cation - City or T		
altile	mit. Partme bortan Injur		21. Signature of F		-	Parl	klawn Mer 22	morial 2. Name an	Park d Address		1, 2008		ville, MD Funeral		
ă	permi Depar Impor any Ir	1	19 mi	e S	Scerl	0				Blvd W, S					
	Physician /Medical Examiner	er	shock, or her Immediate Cause disease or conditi resulting in death)	art failure. List (Final on	Due to	caused the dea each line. zheimer's (or as a conse	s Disease		e or aying,	such as cardiac	or respiratory a	arrest,		Approximate Interval Betwo	een eath
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<u>=</u>	nding Physician; Th th, : After this certificate s funeral director, pag	Be	25. Was case refe examiner?	_	Hoopital	11	7500 to the		Othor	26. Place of Dea			6 □Other (Spec		
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0	Attending r death. sctor: After by the fune	atioi	1X Natural 2 ☐ Accident	5 Pendir investi		nth, Day, Year)	injury	М		es 2□No					
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State

Registrar

SAYED

31. Date filed (Month, Day,

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Pockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYED EISAYTAD 9:7/5 Medita

Registrar's Signature

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Year)

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State of Maryland / Department of Health and Mental Hygiene (

			1 - State Registrar	State of Marylan		tificate of De			gierię () (Reg. No.	JU	1334/
	Physic /Medi		1. Decedent's Name (First, Middle, Last Glenn D.	Ross				2. Date of Dea	ath 28 5 2008	3 ^{Yeer}	3. Time of Death 11:30 p M
}	Exami		4a. Fecility Name (If not institution, give Clinton Nursing	· ·	er	4b. City, Town, or Lo	cation of Death		4c. County		rges
	Funeral Director		311 30 7302 1	7. Age (In yrs. 80	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Mar	, Year 928	9. Birthp	place (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Prince Ge		y. Town or Lo					10d. Inside City Limits	
	ith with the 23e or 28s	Funeral Director	10e. Street and Number 9211 Stuart Lane		····	10f. Zip Code 20735			10g. Citizen of W		itry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show say injury or other traumatic event, I'ra Mcdical Examinate found be multiled at ance.	by Funer	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Amed Forces? 1	ti	Vas Decedent of Hispa Yes, specify Cuban, N ☐ Yes 2 XNo S	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- Americ c, White, Blac	
21215-0036	within 72 h ene. then *natu re Medicel	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	ent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of work	ring	16b. Kind of Bu		
Maryland 2	should be filed nd Mental Hygi marked other amatic event, I	To Be Co	8th 17. Father's Name (First, Middle, Last) Alfred Ross, Sr.					e (First, Middle, Thornt	Maiden Sumame		
	and 2 sho ealth and I m 27 is me		19a Informant's Name/Relationship (Ty. Vickey A. Wright	-Smith	131		ania Av	e., S.E			Code) n, DC 20003
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State G1	emetery, crem Lenwood	atory or other place) Cemetery	04-0		20c. Location - 0	gton,	D.C.
Ba	Depar Impor eny ir		21. Signature of Funeral Service License	Bacon, as	36/ 3	Name and Address of H. Bacon 447 14th S	fracility Funera Street,	l Home, N.W. Wa	Inc. shington	n, DC	20010
	Physician population and physician are the burial-transit as the burial-transit	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) a. ATTERISTICATE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
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	To tr comp		29b. Signature and title of certifier	m		29c. License nur		2	9d. Date signed		**
	2		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, P		n/		, , ,	_ 50	
	Sta Registra		31. Date filed (Month, Day, Year) APR n 9 2008	32. Registrar's Signatu	ire	·					

		1 - For State Registrar	State of Mar		ertificate of		,	giene Reg. No. 200	8 133	348
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	dical niner	4 F. W. M. M. W. W. M. M. M. M. M. M. M. M. M. M. M. M. M.		ALSTON	4b. City, Town, o	or Location of Death	04	18 2008 4c. County of D		
LAGII		WMHS - MEMORIA	L CAMPUS		CUMBER			ALLEG		
Funer Directo		5. Social Security Number 6. S 705-10-8722 Usual Residence of Decedent	IDM 2DF	(In yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 1	9. 1918	Birthplace (State or Country) MD	Foreign
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ne Mar 8a-fsl	Director	MD Alleg	any	Cui	mberland				1 Yes 2	2 No
ath with the 23a or 2	ral Dire	10e. Street and Number 13117 Williams			10f. Zip Code	21502		10g. Citizen of What	A	
ING 21215-UU36 be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 □ Yes 2 🗷 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ Xo		pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, /hite, etc. white	
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	은	Charles E. Ra 19a. Informant's Name/Relationship (19h Mail	ing Address (Street			te Ralston er, City or Town, State	o Zin Codo)	
		Shirley Ralston	wife	13	117 Willia	ms Road	SECum	nberland	MD 2150)2
0 80 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Seremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			osition (Name of ematory or other pla uneral Home		Date 4/19/2008	20c. Location - City Cresapt		ИD
Baltim permit. Pag Department Important;	ouce.	21. Signature of Funeral Service Lices	nsee	2	2. Name and Addre Scarpe					
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rtificate ng phy as the	Medical									
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ate T							1∐ Yes		1? ′es 2□ No	
r VITal yslclan: \[\] is certifical director, p	o Be	examiner? 1 ☐ Yes 21☑ No	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth		th <i>(Check only o</i>	<i>ne)</i> dence 6 ⊟Other <i>(S</i>	Inecifu)	
on or ding Phy h. After this funeral d	J:UC		28a. Date of Injury (Month, Day Y	/ear) 28b. Time				now injury occurred	pouny)	
UNISION I or Attending after death. Director: Afte	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		At home form a		Yes 2 □ No	Opt Leasting (f	Short and Marie and	D D t. M	
DIVISION OF VITA Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:		building, etc. ((Specify)			City or Tou			er,
the Hosp hin 24 hou the Fune mpletely fil	Medical	29a. Certifier 1 Certifying Pt (Check only one) 4 Medical Example (Check only one)	nysiclan: To the best of a miner: On the basis of ea and manner state	xamination and/or i	th occurred at the ti nvestigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)	
To the within 2 To the comple	Σ	29b. Signature and title of certifier	1 26	0	29c. Licens			29d. Date signed (M	onth, Day, Year)	
1		30. Name and address of person who	completed cause of deat	th (Itam 23a) (Type	Print)	1486	5	APRIL 1	3- 20	08
		ROBUSTIANO I	BARRERA	1 M. D.				MBERUAN	D. MD	1
Regis	State	31. Date filed (Month, Day, Year) APR 2 4 2008	32. Registrar's	s Signature	2 .					
DHMH 17 Rev			possible of	A VADORA						

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Tuna!

APR 24

Mell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

625 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

D46344 April 17, 2008

Ave. Cumberland, Md 21502

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma		ertificate of			leg. No.	008	13350
	Dhysisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day	Year	3. Time of Death
-55	Physici /Medi		Conra	d William S	tonebanks,	III		Apri1	05	2008	4:50 pM
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c, Co	unty of Death	
			Holy Cross H				Silver Spri			Montgo	
ti r	Funeral Director		220-40-3780	ex 7. Age Maria 2 F	(In yrs. last birthda) 63 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day February	, Year)	Cour	place (State or Foreign ntry) .ct of Columbia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					10d, Inside City Limits
	shov shov	7	,		,,		ver Spring				1 ∐Yes 2 kk No
	the M 28a-f otifie	Director	Maryland Montg	omery		10f. Zip Code	ver shring		10a. Citizer	of What Cour	ntry?
	with a or		416 Marshall	Manage Drive		Toil Zip Code	20905			U.S.A	W.
	eath ns 23 musi	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No-	14.	Race - Americ	can Indian,
336	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 X No		o Rican, etc.)		Black, White, pecify:	etc. White
21215-0036	- 4 65	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(Gir	edent's Usual Occup le kind of work done DO NOT use retire	oation during most of wor d)	king	16b. Kind	of Business/In	dustry
12	ie the sit	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+ 2	•)	ster Electr			Co	ontractio	19
d 2	be filed vital Hygie d other leevent, the		17. Father's Name (First, Middle, Last					ne (First, Middle,			-0
Maryland	0 K + 0	To Be	Conrad William S	•	· .		Elear	or Campbe:	11		
<u></u>	d 2 should th and Men 7 is marke traumatic	F	19a. Informant's Name/Relationship (iling Address (Street				own, State, Zip	o Code)
N	nd 2		Patricia Y. Stoneba	nks - Wife	416	Marshall Ma	nor Drive.	Silver Sp	ring, N	Maryland	20905
<u>a</u>	s 1 and 2 f Health item 27 I		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	<u> </u>	Date		tion - City or To	
Baltimore,	Pages 1 and ment of Health ant: If item 27 ury or other t		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			coln Cremato	1	4/2008	Bren	twood, M	aryland
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	(1)	'	22. Name and Addre		Home, Inc.			
ш	2011		· Umanda,	Luder	urg	11800 New H	ampshire Av	enue, Silv	ver Spi	ring, Man	ryland 20904
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not e	nter the mode of dyi	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_a. End-St	age Congest	ive Cardio	yopathy				Years
8	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	Examiner	L	Sequentially list conditions,	b. Syncop							
_	ad sit	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	ecute and	Examiner	that initiated events resulting in death) Last	C	consequence of):				-		
68760,	tificate be executed ig physician and as the burial-transit			200 10 (01 00 0							
387	phys the	l edical		_d							
	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome p	f pregnancy				230	d. Date of deliv	erv
Box	leath cert attendin	ciar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at t		B □Ectopic pregnanc □ Other (specify) _	У			Month	Day Year
P.O.	that the de ned by the	Physician/	9 Unknown	9□ Unknown							
	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use	contribute to t	the cause of death?
Ę	w requires been sign should be	d be	Type 2 Diabetes Mel	litus				1 🗆 Y	′es 2🕱	No 3□ Pro	bably 4 □Unknown
Records,	aw re s bee	Completed by						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
Æ	The law	oml						autop perfo	rmed?	death?	2□ No
Vital		Be C	25. Was case referred to medical	ex-			26. Place of Dea	ath (Check only o			
>	G: 55	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗷 Inpatier	it 2 ☐ ER/Outpat	ient 3 DOA Ot	her: 4 Nursing H	lome 5 Resid	tence 6 [☐Other (Speci	ify)
J Or			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day			ry at	28d. Describe h	ow injury o	occurred	
Ö	Attending r death. ector: Afte by the fune	atic	2 ☐ Accident investigatio	n			Yes 2□No				
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (S City or Tox	Street and I vn, State)	Number or Rur	al Route Number,
	ital or irs af ral D										
	To the Hospital or Attend within 24 hours after death to the Funeral Director:	Medical		hysician: To the best o miner: On the basis of and manner state	examination and/or						
	o the control of the control	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date :	signed (Month,	, Day, Year)
	(3)		Barbara Sup	mich RS	u un	T.	0065485		0	4-05	- 2008
	2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print)	0.1				
			Barbara Ann Supar			Glen Road, S	ilver Spri	ng, Maryla	nd 209	10	
		ate	31. Date filed (Month, Day, Year)		r's Signature	0.16					
	Regist	rai	APR 0 9 201	18 Magica	13 /40						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Year **Physician** 2:17A. [™] Edna E. Syreika April 6, /Medical 4b. City, Town, or Location of Death Takoma Park County of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 18, 1924 9. Birthplace (State or Foreign Social Security Number 193-16-9971 **Funeral** Days Hours 1 □ M 2 🔀 F Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Prince George's West Hyattsville Maryland 1 XYes 2 □ No iral", or items 23a or 28a-f sh Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20782 1417 Torrey Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married _{Specify:} White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Lucas John Echalk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1417 Torrey Place West Hyattsville, Maryland 20782 Stanley C. Syreika -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery4/11/2008 Cincinnati, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician icule YDAYJ (Prebrova disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

12

State 31. Date fill
Registrar

14300, CAC 31. Date filed (Month, Day, Year) APR 0 9 2008



30. Name and address of person who completed cause of death (Hum 23a) (Type, Print),

Doinder Strigh, M.D.

145660

MD 2011-

-08

(N,

		1 - State Registrar 1. Decedent's Name	(First Middle 1 a	st)		Cel	rtificate	9 01 1	Jean	10	. Date of De	Reg. No.		3. Time of Death
nysici	an			31)							Month	Day	Yeer	S. 14110 S. 250201
Medic xamin		Viola Kerr 4a. Fecility Name (If I		re street and numbe	r)		4b. City.	Town, or	Location of		pril 6,		County of Dea	12:45 p
amun	er	Montgomery			,		Olne					Mon	toomery	
eral		5. Social Security Nur	mber 6. S	Sex 7. A	lge (In yrs.	last birthday)	If Under Months		If Under 24	Hrs. g	Date of Bir (Month, Da		9. Bir	thplece (State or Fore
or		577-40-3126	5 1	I□M 2 X 0F	97	Yrs.	MOITHIS	Days	riouis		or 27,			ρ <u>α</u>
		Usuel Residence of D 10a. State	10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limi
	5	200			100.00									1 ☐ Yes ŽŽ
	ect	MD 10e. Street and Numi	Montgomer	У		Rockvil	Le 10f. Zip	Code			T	10a Citi	zen of What Co	ountoy?
	ā	13504 Keati						0853				USA		,
	Funeral Director	11. Marital Status		12. Was Deceder		.S. 13.1	Was Deced	ent of H	ispanic Origin n, Mexican, l	? (Speci	fy Yes or No	-	14. Race - Am	
	Ē	1 Never Marrie	d 2 Married	Armed Forces		1	1 Yes, spec 1 □ Yes			Puerto Hi	can, etc.)		Black, Whi	ie, eic. nite
	l by	3 ₩ Widowed 4	Divorced	If Yes, Give Year or Dates	:		1∟Yes 4	No EME	Specify:				Specify: WI	1100
	Completed	(Specifi	15. Decedent's E	ducation ade completed)		16a. Dece	kind of wor	k done d	during most o	of working	,	16b. Ki	nd of Business	/Industry
	mpi	Elementary/Second		College (1-4o	r 5+)		DO NOT us	e retired)					
		12 17. Father's Name (F	Time Middle Last	1		Secre	tary		19 Mothod	Alama /	First, Middle		cation	
	Be			,								, ivialueri	Juliane)	
	ဥ	Howard J. 19a. Informant's Nam		Time Print)		10b Mailie	a Addross	(Stroot	Martha			ar City o	r Town, State,	Zin Code)
ľ		Marra S. Di											, rown, orace,	Lip doddy
		20a. Method of Dispo		ncer		lace of Dispo	sition (Nan	ne of	ace, Ro	Da			cation - City or	Town, State
		1 XBurial 2 ☐		Removal from Stat	e	emetery, crer Lincoli				47 77	2000	Dream	twood, MI	`
		21. Signature of Fund			FOL									Home Inc.
		Ann		12 Wass	rer								MD 20901	
er	cai Examiner	Sequentially list conditions, leading to make a cause. Enter under Cause (Disease or in that initiated events resulting in death) La	njury	b. Due to (or a										
	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 m 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	I death 3	Ectopic pr Other (sp					2	23d. Date of de Month	livery Day Year
	by	Part II. Other signific	cant conditions of	contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco u Yes 2[o the cause of death?
	Completed										24a. Was auto perfo		prior to death?	utopsy findings availal completion of cause of
	Be (25. Was case referre	ed to medical					-		f Death (Check only o	one)		
	2	1 ☐ Yes 2⁄☐-N	10	Hospital: 1 thipa	tient 2 🗆	ER/Outpatier			4 🗆 Nurs	ing Home	5 🗆 Resi	dence (6 □Other (Spe	acify)
	ion:	27. Manner of Death 1 ☐Natural 2 ☐ Accident	5 ☐ Pending investigatio		jury Day Year)	28b. Time of Injury	M 2	Bc. Injun Worl	yat k? Yes 2⊟No		d. Describe	how injur	y occurred	
	cat	3 Suicide	6 ☐ Could not be determined	286. Place of I	njury - At he etc. <i>(Specif</i>	ome, farm, str y)	eet, factory	, office			City or To	wn, State	·) 	ural Route Number,
	Certification:	4 Homicide											and manner a	
		4 ☐ Homicide 29a. Certifier	1 Certifying Pt	nysician: To the bes miner: On the basis and manner	of examina	owledge, death tion and/or in	h occurred vestigation,	at the tin in my o	ne, date and pinion, death	occurred	d due to the l at the time,	date and	I place, and du	s stated. e to the cause(s)
	Medical Certificat	4 Homicide 29a. Certifier 1 (Check only 2	2 Medical Exa	miner: On the basis	of examina	owledge, death	vestigation,	in my o	ne, date and pinion, death e number	place, an	d due to the at the time,	date and	I place, and du	e to the cause(s)
כטווקווסוסין ווויפס ווו בין עופ נטופומן מוופכיניי, ביאפים ב		4 Homicide 29a. Certifier 1 (Check only 2 one)	itle of certifier	miner: On the basis and manner	of examina stated.	ALP	vestigation,	in my o	pinion, death	place, an occurred	d due to the lat the time,	date and	I place, and du	e to the cause(s)

DHMH 17 Rev 1/2001

			1 - State State Registrar	of Maryland / Depa Cer	artment of F			ene a. No. 2008	13353		
F	Physici	an	1. Decedent's Name (First, Middle, Last) Alice Caroline Sell				2. Date of Death Month	Day Year	3. Time of Death		
	/Medio Examir		4a. Facility Name (If not institution, give street and not 1801 East Jefferson St.		4b. City, Town, o	r Location of Death	April 8	, 2008 4c. County of Deatl Montgomer	•		
	Funeral	##:-	5. Social Security Number 100-12-4186 6. Sex 1□ M 2 🖫 F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	y nplace (State or Foreign untry)		
فيد	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		Oct. 3.	1909 Ger	many 10d. Inside City Limits		
	e Maryla 3a-f sho tified at	ctor	MD Montgomery	North Bet				1 Y Yes 2 No			
	th with th	Funeral Director	10e. Street and Number 1801 East Jefferson St	reet #328	10f. Zip Code 20852			-	Citizen of What Country?		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funer	Armed F	2⊠ No live	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.		
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natui the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College) (Give	DO NOT use retired	during most of work	king	6b. Kind of Business/I	ndustry		
/land 2	tal d c	To Be Co	17. Father's Name (<i>First, Middle, Last</i>) Abraham Freymark			18. Mother's Nam Rosa We	e (First, Middle, Mi				
, Mary	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Vivian Faden / Daughter	11605	Hitchin	g Post Ln	. Rockvi	City or Town, State, Z	852		
imore	Pages 1 Iment of Hu Iant: If iter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	National	natory or other plac Cremato:	ry 04/09	/2008 1	oc. Location - City or Falls Chur	ch, VA		
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Fundal Service Licensee	I			-	er's Sons ington, DC			
	Physician			caused the death. Do not ent each line. estive Heart I		ng, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death Years		
	/Medical Examiner			(or as a consequence of):							
-	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	(or as a consequence of):							
8760,	ficate be executed physician and s the burial-transit	dical Ex	Due to								
.O. Box 6	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)	y		23d. Date of deli Month	very Day Year		
1	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
Vital Hecords,		Completed	25. Was case referred to medical					ed? prior to death? ∇No 1 □ Yes	topsy findings available ompletion of cause of 2□ No		
	Physiclan: this certificatal director,	To Be	examiner?	Inpatient 2 ☐ ER/Outpatien	t 3 DOA Oth	Ot.	h Check onl one	ice 6 □Other (Spec	zifv)		
DIVISION OF	nding Ph tth. r: After th e funeral		27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation 28a. Date (Mod	e of Injury nth, Day Year) 28b. Time of Injury	Wor		28d. Describe how		•••		
DIVIS	ne Hospital or Attending P n 24 hours after death. he Funeral Director: After t pletely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plac built	e of injury - At home, farm, straing, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	To the Hospit within 24 hour To the Funer completely fille	Medical (29a. Certifier (Check only one) 1 ★ Certifying Physician: To the 2 Medical Examiner: On the and mai	e best of my knowledge, death basis of examination and/or in nner stated.	n occurred at the til vestigation, in my o	me, date and place, opinion, death occu	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)		
	To the To the Complet	M	29b. Signature and title of certifier		29c. Licens D006			d. Date signed <i>(Montf</i> 04/09/2008			
•	5		30. Name and address of person who completed cau Michael N. Solomon MD 5			O Chevy C	hase MD	20815			
2	* Sta			Registrar's Signature	reli I						

			1 - For State Registrar AMEND#8perFH4-	State of Maryla	-	artment of F rtificate of			jien o () () ()	13354	
	Physici /Medic		1. Decedent's Name (First, Middle, Last ESTH	ER.	SCH	IFF		2. Date of Dea		3. Time of Death	
	Examir		4a. Facility Name (If not institution, give Hebrew Home of Gr 5. Social Security Number 6. Se	eater Washing	ton . last birthday	Rockvil	If Under 24 Hrs	8. Date of Birth	4c. County of Deal Montgome 3-16-1909Birl	ery	
	Funeral Director			JM 282F 9	9 Yrs.	Months Days	Hours Min	(Month, Day Mar. 15	r, Year) Co	ew York 10d. Inside City Limits	
	the Maryla 28a-f eho	Director	Maryland Montg		ockvil				10g. Citizen of What Co	1 X Yes 2 □ No	
	eath with	Funeral Di	6121 Montrose Ro	ad 12. Was Decedent Ever in I	J.S. 13.	20852		Specify Yes or No-		nited States	
980	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f ehow dical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	Specify:			
1215-0	within ane. than	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0·12) 12		(Give	dent's Usual Occup a kind of work done DO NOT use retire 1aims Age	during most of wo d)	orking	16b. Kind of Business. Insurar		
Baltimore, Maryland 21215-0036	should be filed and Mental Hygis marked other	To Be C	17. Father's Name (First, Middle, Last) Jacob Goodman			J	1	me (First, Middle, . Unkr			
, Mar	s 1 and 2 should Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (TAL) Alan Schiff / Son		14324	Yosemite		Rockvill	r, City or Town, State, . .e MD 2085	3	
imore	2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	• Linco	osition (Name of imatory or other pla oln Crema	tory 4/1	1/2008	Brentwood,		
Balt	permit. Page Department of Importent: if any injury or		21. Signature of Funeral Service Licens		10	040 Rockv	ille Pik		ille, MD 20)852	
	Physician /Medical	ō .	23a. Part1. Enter he disease or comp shock, or high failure. List only of Immediate Cause (Final disease or condition resulting in death)	dications that caused the dearne caus in each line. a. Due to for asia conse	141	HYDU	JR16	NSIC		Approximate Interval Between Onset and Death	
	Examiner	e	LURE								
90,	death certificate be executed e attending physicien and nd for use as the burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
09289	ntificate b ng physic s as the b	Medical	IF FEMALE:								
.O. Box		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	livery Day Year	
ords, P	w requires that the been signed by th should be detache	þ	Part II. Dther significant conditions of	entributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to es 2 ⊠No 3 □ P	o the cause of death?	
of Vital Records,	The law ete has t page 2 s	Completed						24a. Was a autopoperfor 1 🗌 Yes		utopsy findings available completion of cause of	
Z: Z:	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		1.04	F	ath (Check only or			
ŏ	Phys this aldi	7.	1 ☐ Yes 2 1 No 27. Manner of Death	1 L Inpatient 2L	ER/Outpatie	nt 3LI DUA	4 Privursing		ence 6 Other (Spe	icify)	
Division	ding After fune	Certification;	1 DNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	DB GRee Blood of Injury. At home form street factors office. 28f Location (Street						ural Route Number,	
Ö	To the Hospitel or Attent within 24 hours efter deatl to the Funerel Director: completely filled in by the	al Certi	29a. Certifying Phy	building, etc. (Spec ysician: To the best of my kr	nowledge, dea	th occurred at the ti			cause(s) and manner a		
	To the Ho within 24 h To the Fu completely	Medicai	(Check only 2 Medical Examone) 29b. Signature and attle of certifier	iner: On the basis of examinand manner stated.	nation and/or in	29c. Licen	se number		Od Date signed (Mon	th Day Vasri	
-	23		Described 30. Name a Laddress of person when	completed cases of dea	28a) (Type	Print) // N	954 TD 011	-00 D	ROILO.	5, 2008 HD20852	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	y run	1000	WV, XI	ievius,	MULOSSE	
	Registr		NDD 1 0 201	18	H. Ma	OAK D					

			For State Registrar	State	of Ma	aryland / Dep <i>Ce</i>	artmen e <i>rtificat</i>			and M		giene Reg. No. 2	008	13355
Œ			Decedent's Name (First, Middle	, Last)							2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		KENNETH BERNA	ARD SHAV	J						03-30-2		1 eai	0926 M
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City,	Town, o	r Location o	of Death		4c. Co	ounty of Death	1
	3		WASHINGTON ADV				TAKO		PARK If Under	24 Hrs	O Data of Bird		CGOMERY	
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age	e (In yrs. last birthda Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 02-13-	v. Year)	Cou	pplace (State or Foreign Intry) 1and
-	Director		215-20-8908 Usual Residence of Decedent		00						02-13-	1920	Haly	Tand
	ylanc now		10a. State 10b. County			10c. City, Town or	Location							10d. Inside City Limits
:	a-fsl	cto	Maryland Montgo	nery		Takoma :	Park							1 🔭 Yes 2 🗌 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Coเ	untry?
	s 23a	ral	7525 Carroll		andant [Tues in LLC 46		0912		igin? (Cn	noify Voc or No		A. Race - Amer	ican Indian
	item item ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was De Armed I	Forces?		If Yes, spe	cify Cub	an, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	1 1	Black, White	e, etc.
936	urs af al', or xam	by	3 ∰Widowed 4 Divorced	If Yes, (Year or	Give	WWII	1 ☐ Yes	2 L TNo	Specify:			Sp	pecify: Wh	nite
215-003	filed within 72 hours after death with the Maryland Hygiene. Hydiene. Then 123a or 28a-f show ther then "natural" or items 23a or 28a-f show ent, the M-dical Examiner must be notified at	Completed	15. Decedent	's Education		16a. Dec	edent's Usu	al Occup	pation	t of work	ina	16b. Kind	of Business/l	ndustry
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2	led w lygier her th	ខ	Unk	(==4)			Salesm	an	10 Moths	ar's Name	First, Middle,		ate Ind	lustry
and	ntal F ed otl	Be	17. Father's Name (First, Middle,	Last)			Unk		10. MOUTE	SI S Maine	e (First, Middle,	Maidell 30	nname)	Unk.
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Memtal Hygiene. The fire them 23a or 28a-f show tem 21 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은	19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Ma			and Numbe	er or Rur	al Route Numb	er, City or T	own, State, Z	ip Code)
E E	nd 2 salth al		Claudia John/	mardian		6420	Allen	town	n Rđ.	Car	np Spri	nos. M	m 2074	47
J.			20a. Method of Disposition	-	01-4-	20b. Place of Dis				J	Date	20c. Local	tion - City or	Town, State
	Pages nent of I ant: If Ita ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		m State	Riverdal			1 -	04-07	7–2008	River	rdale,	Maryland
alt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service		1.00	107/	22. Name ar			,				
20	ă.o.⊑ ≅ ō			man									Land, N	Approximate
9			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause or	t caused n each lir	ithe death. Do not e ie.	enter the mod	же от ауı	ng, such as	cardiac	or respiratory a	rrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			clerotic a consequence of):	Heart	Dise	ease					
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. Box	leath certifi attending I for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	e birth	2 Fetal death	B Ectopic p		у			230	Month	Day Year
o	The law requires that the death certif tte has been signed by the attending age 2 should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	9□Unl				• / -						
ď.	res that signed b	by P	Part II. Other significant condition	ons contributing to	death b	ut not resulting in the	underlying	ause gi	ven in Part I	1.	23e. Did t	obacco use	contribute to	the cause of death?
ğ	w require been sig should b										10	Yes 2	No 3□Pr	obably 4 □Unknown
Records,	law ras be	Completed									24a. Was	psy	24b. Were au	topsy findings available completion of cause of
		Cor									perfo 1⊟ Yes	rmed? 2. No	death? 1 ☐ Yes	2 No
Vital	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:				Lot	26. Place	e of Deat	h (Check only o	one)		
ō	Phys r this ral dir	 To	1 Yes 2 No 27. Manner of Death	11	☐ Inpatie te of Inju			JA	4 ∐ Ni	ursing Ho	ome 5 Resi 28d. Describe			cify)
0	ding I h. : After funer	tion	1 Natural 5 Pendin 2 Accident investig	g (M	onth, Da	y Year) Injur	м	28c. Inju Wa 1 [irk?]Yes 2 🗍	No				
Division or	I or Attend efter death Director:	ifica	3 Suicide 6 Could determ	inna 200, Fla	ice of inju	ury - At home, farm, c. <i>(Specify)</i>	street, factor	y, office			28f. Location (Number or Ru	ıral Route Number,
	tal r rs afte al Dir ed n	Certification:	4 Dilottiloide		ilding, co	u. (upcony)						wir, Olaley		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, i	Medical		Examiner: On the		of my knowledge, de f examination and/o ated.								
	To the within to the complex c	Me	29b. Signature and title of certifie		al	Km			se number	776		29d. Date :	signed (Month	
0	a		30. Name and address of person						, ,			/		-
K	- <i>O</i>		Doris Bustos,					411	Wash:	ingt	on, D.C	. 200	10	

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State 31. Registrar

31. Date filed (Month, Day, Year)
APR 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2008 0120 April /Medical Lewis Shelton James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince George's Prince George's Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral №** M 2□ F Days Hours Months Director 79 Virginia 579-30-4379 March 22, 1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10 20019 237 - 63rd Street, NE United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 ☐ Married African Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years GSA Dispatcher Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth Be James W. Shelton Rosie Nel Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 - 63rd St., NE Washington, DC 20019 Thresa H. Shelton - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury or Department Important: If any injury or Quantico Nat'l Cemt. Apr 14, 2008 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ture of Funeral Service Litense 24 Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock scheart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner MRSA Bacteriemia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Aspiration Pneumonia that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Respiratory Insufficiency Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No ed by the a 9□Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Tyes No 3 Probably 4 Unknown Endstage Renal Disease, Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Erosive Gastritis, Decubitus Ulcer, Anemia page 2 autopsy Colon Cancer Yes 212 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🙀 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31528 April 5, 2008

State Registrar

31. Date filed (Month, Day, Year) APR 0.9 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Dr. Margaret Akpan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death S SOOS **Physician** 740 M April Willa Anna Scheve1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rehab + Nursing Ctr. Wicomico LISDUTU 0 If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 X F 4-30-1929 78 Delaware Director 220-26-8531 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 21 ☐ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2709 Old Ocean City Road 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie ۴ Reve1 Ethel Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pat Townsend - niece 34429 West Street, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Springhill Memory Gds; 4-11-2008 | Hebron, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Parm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 107 eardisease or condition resulting in death) -07 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 4No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 100 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation (Month, Day Year 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Civic Ave

200

Robins

APR 1 0 2008

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			_ FOI	partment of Health and Certificate of Death	ivientai n	Reg. No		13359
F	Physicia	n l	1. Decedent's Name (First, Middle, Last)		2. Date of Month	Da	y Year	3. Time of Death
	/Medic		Debra Tete	rvin 4b. City, Town, or Location of Dea	April_		008 County of Deat	6:20 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 6271 Golden Hook	Columbia			oward	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of			hplace (State or Foreign untry)
	Director		110-09-8088 1□M 2XF 89 Yrs	3. World's Days 110013 Will	Oct.	11,	1918 0	hio
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location				10d. Inside City Limits
	Maryli f sho	to	Maryland Howard Columb	ia				W∏Yes 2 No
	th the or 28a	Director	10e. Street and Number	10f. Zip Code 21044		10g. Ci	tizen of What Co	untry?
	ath wii		6271 Golden Hook				U. S.	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	specify Yes or rto Rican, etc.)	No-	14. Race - Ame Black, White	
320	urs aff	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:			Specify:	White
5-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Di (Specify only highest grade completed) (G	ecedent's Usual Occupation Sive kind of work done during most of wo fe. DO NOT use retired)	orking	16b. k	Kind of Business/	Industry
2	vithin ne.	du	Elementary/Secondary (0-12) College (1-4or 5+)				Own Ho	m o
2 2	filed v Hygie other t		12 Years H 17. Father's Name (First, Middle, Last)	omemaker 18. Mother's Na	me (First, Mide	dle, Maidei		ine .
a	Mental Mental arked o	To Be	Peretz Rubin	Devor	ah (Una	scer	tainable)
Maryland	2 should and Men is marke aumatic		, , , , , , , , , , , , , , , , , , , ,	lailing Address (Street and Number or F				•
	ges 1 and 2 should it of Health and Men If Item 27 is marke or other traumatic			725 Lakeside Drive	, Clark		ocation - City or	
00	Pages nent of H int: If lite		1	isposition (Name of crematory or other place) Mem. Gdns 4/6	/2008		ney, Mar	
Baltimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Licensee		•	1		-
ñ	Der Imp	100	Sonald C. Stattlemys	22. Name and Address of Facility Danzansky-Goldber II70 Rockville Pi			ſë, Mary	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardi	ac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician // Medical		Immediate Cause (Final disease or condition resulting in death)	Heart tribul				Onset and Death MeJTh
	Examiner		Due to (or as a consequence of)	New Disease				(EA)
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c. Diacetes	J				(1
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of)	Mellitus				TEARS
68760,	ficate be executed physician and is the burial-transit	al E)	Due to (ut as a consequence of)	•				
687		edical	d					
Box	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		1	23d. Date of de Month	livery Day Year
O.	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		-	Worth	bay real
σ.	res that the signed by be detact		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. D	id tobacco	use contribute to	o the cause of death?
Records,	quires n sign uid be	d by			. 1	☐ Yes	2 ₹ No 3□P	robably 4 □Unknown
000	aw require as been sig 2 should b	Completed			24a. W	/as an utopsy	24b. Were a	utopsy findings available completion of cause of
		Com			1□ Ye	erformed?	death? lo 1 ☐ Yes	s 2□No
Vital	sctor, pag	Be	25. Was case referred to medical examiner? Hospital: 4 The street of TER (2) the street	26. Place of D				
Ö	Phys er this eral dii	1: To	27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at			6 ☐Other (Speurred	ecify)
<u>o</u>	nding ath. r: Afte re fune	atior	1 🕅 Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 Yes 2 No				
Division or	or Atte ter dea irecto n by th	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office		n (Street a Town, Sta		ural Route Number,
	pital cours af eral D		29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and pla	ce and due to	the cause	(s) and manner a	s stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		29d. D	Pate signed (Mon	th, Day, Year)
)	12		· Alexander	022856		144	12.15,2	.00
			30. Name and address person who completed cause of death (Item 23a) (The state of t	itte Parybeat PE	م ري	Cema	nol,	21044
¥	Sta	te		1 *	<i>9</i>		-	
	Registi	ar	APR 0 9 2008 Bergue 15. 16	marke)				

Phy: /M Exa

Fune Direct

		State of Maryland				Mental Hy	giene 1	0.8	13360
		Registrar	Cei	tificate of	Death	2. Date of De	Reg. No.		3. Time of Death
sicia	n	1. Decedent's Name (First, Middle, Last)				Month	Day	Year	
edic		Olga Torres Torres 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Dea	April	02, 200		7:50 P ^M
min	er	Holy Cross Hospital			Spring		Monte		v
ral	-	5. Social Security Number 6. Sex 7. Age (In yrs. le	st birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Bi	rth		ace (State or Foreign try)
or		146-48-6330 1□M 2\sqrt{3}F 9:	3 Yrs.	Months Days	Hours Min		0, 1915	Chi	le
		Usual Residence of Decedent	-				,		21 1-14-01-11-11
	_	,	Town or Lo					11	0d. Inside City Limits 1 ∐Yes 2 🛣 No
	Sch	Maryland Montgomery	Nort	h Potoma	С		40.000		
	ä	10e. Street and Number		10f. Zip Code			10g. Citizen of W		
	Funeral Director	10626 Chisholm Landing Terrace 11 Marital Status 12. Was Decedent Ever in U.S.	12.1	Mas Decedent of I	20878	Specify Ves or N	United	l Sta	
	Ä	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S		Was Decedent of I f Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)	Blac	k, White,	
	۵	If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		IDXYes 2□No	Specify: Ch	ilean	Specify	Wh:	Lte
	Be Completed	15. Decedent's Education	16a. Dece	lent's Usual Occu	pation	orking	16b. Kind of Bu	siness/Inc	lustry
	ple.	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done OO NOT use retire	d)	or King			
	Ö	8	Sea	mstress	r			hing	
	Be	17. Father's Name (First, Middle, Last)					e, Maiden Surnam	e)	
	ို	Richardo Ibacache			Amelia				
		19a. Informant's Name/Relationship (Type. Print)					ber, City or Town,		
		Luis E. Ibacache / Son 20a. Method of Disposition 20b. Pl		Sition (Name of matory or other pla		g Terr;	N. Potom 20c. Location -		
		I Bunai 2 Lacremation 3 Li Hemovai Ironi State			1	/2000	D	1	3/170
o l	}	4 □ Donation 5 □ Other (Specify) Ft. 21. Signature of Funeral Septice Licensee	Linco	In Crema 2. Name and Addr	ess of Facility	/2008 Simple Ti	Brentw	ooa,	MD
ouce.		JA ACA				_	ville, MI	208	52
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. Ust only one cause on each line.							Approximate Interval Between
an		Immediate Cause (Final disease or condition End Stage Con							Onset and Death Years
al		resulting in death) a. Due to (or as a consequ		-	5	- /			
er		Sequentially list conditions b. Pneumonia							Days
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):						
	Examiner	Cause (Disease or injury that initiated events c	ence of):						
	ical E	Bao to (or as a seriosqu	01100 01/1						
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	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant		-			23d. Dat	te of delive	ery
	icia	In the past 12 months? 1 □ Ves 2 ⊠ No. 4 □ Pregnant at time of de]Ectopic pregnand]Other (specify) _	У		Мо	nth	Day Year
	hys	9 ☐ Unknown							
	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause gi	ven in Part I.				ne cause of death?
	ted	Chronic Renal Insufficiency				- 1_	Yes 2 No	3∐ Prob	ably 4 ⊠Unknowr
	ple	Hypertension				24a. Wa aut	s an 24b. Y	Were auto	psy findings available npletion of cause of
2	Con					per 1□ Yes	formed?	death? I □ Yes	2□No
	Be	25. Was case referred to medical examiner? Hospital:		0.	26. Place of D	eath (Check only	one)		
	٦	1 ☐ Yes 2 ☐ No	R/Outpatier 28b. Time o	IL 3 DOA	4 Li Nursing		how injury occur		y)
	tion	1 🖾 Natural 5 □ Pending (Month, Day Year)	Injury	Wo	rk? Yes 2∐No	Edd. Describe	now injury occur	cu	
	fical	3 Suicide 6 Could not be 28e. Place of injury - At hor	me, farm, sti				(Street and Numb	er or Rura	I Route Number,
	erti	4 ☐ Homicide determined building, etc. (Specify)			City or To	own, State)		
.	cal (29a. Certifier (Check only (Ch	vledge, deat	h occurred at the	ime, date and pla	ce, and due to th	e cause(s) and ma	anner as s	tated.
	Medical Certification:	one) and manner stated.				- I			
	2	29b. Signature and title of certifier		29c. Licen			29d. Date signe		
		Barbara Suparich, Pon	1,M		485		9-	3 -	DB
		30. Name and address of person who combleted cause of death (Item			D 1 0	41	and a second		1.0
Sta	te	Barbara A. Supanich, M.D. 150 31. Date filed (Month, Day, Year) 32. Registrar's Signat		est Glen	koad, S	TIVET SI	oring, Mi	209	IU
ان istr		APR 0 9 2008	600	de					
			-						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18, per INF. 1882, 8 / 22/08, WS Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Victor Vazgen Thomasian April 8, 2008 7:30 /Medical а 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F 214-25-8696 72 Sep 29, 1935 Director Iran Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 4522 Sigsbee Road 20906 Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Never Married 2 X Married 1 ☐ Yes X No Maryland 21215-0036 Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Engineering Civil Engineer marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hulie Nazarian ပ Vaqharshak Thomasian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linet M. Thomasian / Wife 4522 Sigsbee Road, Silver Spring, MD 20906 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Apr 11, 2008 |Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFrancis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 Josep. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myocardial infarction /Medical Due to (or as a consequence of) Examiner coronary artery disease Sequentially list conditions, any transport immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Exami Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 ☐ No P.0. detached 9 Unknown ģ signed to 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Jivision or Vital Records, þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1☐ Yes 2 X No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury To the Hospitar or within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director. 1 ∏Yes 2 ∏No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XX ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28426 April 9, 2008

State Registrar

Galen Hallic, MD 10215 Fernwood Road, Bethesda, MD 20817 31. Date filed (Month, Day, Year)
APR 1 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 degistrar's Signature

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar Ram Trehan, MD

31. Date filed (Month, Day, Year)

1400 Forest Glen Rd., Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

D33224

April 8, 2008

20910

		1 - For State Registrar		Ce	rtificate of	Death		Reg. No. 2	0.8	1335	3
Physic	ian	1. Decedent's Name (First, Middle, La					2. Date of D Month	eath Day	3. Year	Time of Death	
/Med		SYLVI			TRENUM		04			240	M
Exami	ner	4a. Facility Name (If not institution, giv WMHS BRADDOCK C			CUMBE	or Location of Dea	ith	4c. County	or Death CGANY		
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday,	If Under 1 Year	If Under 24 Hr	s. 8. Date of B	irth		(State or Forei	gn
Director	li .	200-40-1201	^{1□ M 2} ★ 76	Yrs.	Months Days	Hours Mir	Jul 17	^y ay, Year) 7 , 1931	M	D	
and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Le	ocation				10d. I	nside City Limi	ts
Maryl f sho	to	MD Alleg	any	We	sternport				1	I □Yes 2□N	lo
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?		
th with	a D	21516 Creekside	e Drive SW			21562		U	SA		
tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or N rto Rican, etc.)	lo- 14. Race Blace	- American Ir k, White, etc.	ndian,	
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. The matural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2 □ X io	Specify:		Specify	white		
2 hou atura		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu			
thin 7	Completed	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	orking	[
ed wii	ပ္ပြ	12		<u> Hom</u>	<u>emaker</u>	T		Own H			
The fill had had out	Be	17. Father's Name (First, Middle, Last Charles Edwa				1	•	e, Maiden Surnam ine (Dona	,	orteon	
2 should be and Mental is marked of aumatic even	은	19a, Informant's Name/Relationship (19b. Maili	ng Address (Street						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Debbie Warnick	daughte		6 Roosev			sternport		21562	
of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other pla		Date	20c. Location -	City or Town,	State	
Pages treent of he tant: If ite		4 ☐ Donation 5 ☐ Other (Specif	Sca	•	ineral Home	· i	4/20/2008	Cresa	ptown	MD	
permit Depar Impor any In		21. Signature of Funeral Service Lice	nsee	2	2. Name and Addre Scarpe						
TO BE THE		23 Port Enter the diseas, or com	oli ations that aused the deal	h. Do not en				and, MD 215 arrest,		proximate erval Between	
Physician		mmediate Cause (Final	one cause on each line.	f.					Inte On:	erval Between set and Death	
/Medical		disease or condition resulting in death)	a. Due to (or as a consec	uence of):	CONCIL	no ma			-		_
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pe #s	ine	Succeedially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	0						
xecut and	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						_	
The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		,	, d	,							
ertificating phy	Medical										
eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	v			e of delivery		
e dea the att	Physician/	in the past 12 months? 1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 Pregnant at time of o		Other (specify)			Mor	nth Day	Year	
ires that the de signed by the a		Part II. Other significant conditions of	contributing to death but not res	ulting in the u	inderlying cause oiv	ven in Part I	23e. Did	tobacco use contr	ihute to the ca	use of death?	
uires uires la signe	d by								3 ☐ Probably	N/	٧n
w requir been si should l	lete						24a. Wa	s an 24h V	Vere autonsy f	findings availab	ole.
The far ate has page 2	Completed						aute per	formed? d	eath?	findings availab tion of cause of	f
	Be C	25. Was case referred to medical examiner?				26. Place of De	1□ Yes eath (Check only		□Yes 2□	ING	
nis idi	고 B	1 ☐ Yes 2 No		ER/Outpatie		4 ☐ Nursing	Home 5□Res	sidence 6 🗆 Othe	er (Specify)		
iling P. After After	ion:	27. Manner of Teath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurre	ed		
death death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be		ome. farm. st		Yes 2 No	28f. Location	(Street and Number	er or Bural Bo	ute Number	
al or A	Certification:	4 ☐ Homicide determined	building, etc. (Specia	ý)	out, ideatory, emac		City or To	own, State)	sr or ribrarrio	ute rumber,	
To the Hospital or Attending Plantin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or ir	th occurred at the ti	ime, date and plac opinion, death oc	ce, and due to the	e cause(s) and ma e, date and place, a	nner as stated and due to the	I. cause(s)	
Fo the within Fo the	Me	29b. Signature and title of certifier	0 R		29c. Licens			29d. Date signed	(Month, Day,	Year)	
		N-14-16	anjs/han		10	19318		April Cumbe	1912	2008.	
		30. Name and address of person who	completed cause of death (iter	n 23a) (Type,	Print)	· · · ·	2	^		2150	2
		DK. NAGARAT	NAM RANTI	than	1517 C)ldtown	1 KOAC	Cumbe	erlan	d, MD	
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DHMH 17 Rev 1/2001

ORIGINAL

08-02997
Michael Talbard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lichael Talbard		State of Maryland / Department of Health and Mental 1- For State Certificate of Death		Reg. No.	200	
Physicia Nedical Examin		1. Decedent's Name (First, Middle,Last) Michael Daniel Talbard	2. Date of De Month April 17,	Day Y	rear 3	3. Time of Death 1700 hrs
, '		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. Count	ty of Death	
Funeral	4	Harford Memorial Hospital Havre de Grace 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of B	Harford		place (State or
Funeral Director		214-79-5135 1XM 2 F Yrs. 9 30 Hours N	Min.	18, 200	Foreign	htry)Maryland
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-7		1	0d. Inside City Limits
with the Maryland ns 23a or 28a-f show be notified at once.	ö	Maryland Harford Bel Air	· · ·			1 Yes 2 X No
or 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of \		y?
with the		12 West Ring Factory Road 21014 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or N	USA 10- 14. Ra		an Indian, Black,
death or item	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Wh	hite, etc.	
ural",	اھ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	Specify 16b. Kind of		hite
72 hou n "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Tob. rang or	Dusiness/inc	adotty
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c a de d		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route N	umber, City or To	own, State, 2	
, ME and 2 sl ealth ar em 27 traum?	-	Michael V. Talbard / Father 12 West Ring Factor 20a. Method of Disposition 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of cemetery, 120b. Place of Disposition (Name of Cem	ory Road,	Bel Ai		
Baltimore, MD 2 permit, Pages I and 2 shoul Department of Health and In Important: If item 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Removal from State crematory or other place)	-22-08		,	ryland
altin mit. P partme portan	1	4 Donation 5 Other Specify: HIIITOP SERVICE CORP 4 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. MICCOMAS Funeral			717 130.	Lyrana
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	&dAbir	nadon, M	D 210	09 Approximate Interval
Physician Medical		failure. List only one cause on each line		irrest, shock, or i	leart	Between Onset and Death
kaminer		$\begin{array}{llllllllllllllllllllllllllllllllllll$				
	آةِ اق	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		_	\neg	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). I ast				
cuted and transit		d				
certificate be executed adding physician and ease transit use as the burial - transit	Medical	X UNPENDED AMENDED 23a,27,28a-f, perME, G881 7/9/	'08 TT			
6876 certificate ding phy	١	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre		23d. Date Month		ay Year
Box 687(c death certifica the attending pl ed for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		1		19
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
S, P.O. uires that to n signed by id be detacl	ed by					bly 4 Unknown
cords,	Completed			opsy formed?	prior to co death?	opsy findings available empletion of cause of
of Vital Records, ag Physician: The law require the this certificate has been is neral director, page 2 should I		25. Was case referred to medical 26.Place of Death (Che	1 ✔ Yes	3 2 No	1 🗸 Yes	2 No
Vital hysteian: this certif	o Be	examiner?	ursing Home 5	Residence 6	6 Other:	
ling Ph	<u> </u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describ	e how injury occ	urred	
Division tal or Attendi rs after death.	iğ Eği	Accident Investigation FNd 4/1//08 Fnd 3:15 pm 103 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		(Street and Nur	mber or Rur	al Route Number, City
Divis spital or At ours after d teral Direct filled in by	Certification:	Suicide 4 Homicide Security Specify	or Town Havre	State) 620 de Gra	Count ice, M	ry CLub Rd.
	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca	use(s) and man	ner as stated	d.
F 2 F 8	ŝ∣	29b. Signature and title of certifier 29c. License number		29d. Date si	igned (Mont	th, Day, Year)
		lalmy C.C.M.E.		April 19,	2008	
		 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 	21201			
Sta		31. Date filed (Month, Day, Year) 32. Segistrar's Signature				
Registr	ar	APR 2 4 2008 Regues 18 April	oc	ME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2008 April 3, **Physician** 5:50am Sarah Willen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 8. Date of Birth March 18,1916 Birthplace (State or Foreign
 NY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 ⋤ F 92 042-16-8833 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner ""." 10a. State 10c. City, Town or Location 10d. Inside City Limits TX Yes 2 □ No Director Md. Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9520 Clement Road 20910 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua! Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samue1 Haber Rose Feldler 19a. Informant's Name/Relationship (Type. Print)
Mark Willen/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9520 Clement Rd. Silver Spring, Md. 20910 20b. Place of Disposition (Name of cemetery, crematory or other place)
Teferes Israel 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 04/06/08 West Hartford, Ct. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Chapels 1170 Rockville Pike
Rockville, Md. 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 2 days disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I rector, page 2 s autopsy performed? Yes 2 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes ours after death.

neral Director;
filled in by the fu 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrose Road, Rockville, Md 20832 the ow 31. Date filed (Month, Day, Year) State APR 09 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** April 5, 2008 11:00 Evelyn E. Watkins /Medical p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kensington Park Kensinatan If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F Yrs Director 577-09-1791 Nov 13, 1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shore Director 1 ☐ Yes XX No MD Montgomery Kensingtan 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3620 Littledale Road 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 School Crossing Guard Public_School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond German Georgia Colburn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Norbeck Rd, Silver Spring, MD 20906 Charles Mey / Son Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 State 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Apr 10, 2008 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee mellariellarne 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) atherosclerotic heart disease /Medical Due to (or as a consequence of): Examiner congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit dementia Due to (or as a consequence of): by Physician/Medical Box IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Day Year 5 Other (specify) P.0. page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2X No 1 ☐ Yes Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death s after death. I Director: After t 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 🔀 Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

To the I within 2

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and little of certifier

Ajay Reddy, 31. Date filed (Month, Day, Year)

M.D.,

09

2008

Medical

and manner stated.

6320 Democracy Blvd, Bethesda, MD 20817

🗗 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D53691

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

April 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of H			giene , Reg. No.	2008	13367
		康	Decedent's Name (First, Middle, Last)					2. Date of De	ath	V	3. Time of Death
ŀ	Physici /Medic		BAKER	L. WAS	HINGTO	N		Month APRIL	Day 7	2008	1:39 A M
)	Examin		4a. Facility Name (If not institution, give s 1105 ALVERTON ST				Location of Deatl		4c. C	ounty of Deat	th
		*	5. Social Security Number 6. Sex		last hirthday)	CAPIT If Under 1 Year	OL HEIGH				GEORGE 'S thplace (State or Foreign
Н	Funeral Director			M 2□F 57	Yrs.	Months Days	Hours Min.	JULY	y, Year)	Co	ARYLAND
~			Usual Residence of Decedent					, och ,	, 1,,,		
	arylar show d at	_	10a. State 10b. County		y, Town or Lo						10d. Inside City Limits ▼□Yes 2□No
	the M 28a-f iotifie	Director	MD PRINCE GI	EORGE'S	CAPITO	L HEIGHTS			100 Citize	en of What Co	21
	3a or	Ö					_			SA	,
	death	Funeral	1105 ALVERTON STRE	12. Was Decedent Ever in U Armed Forces?	.S. 13.	2074 Was Decedent of H If Yes, specify Cuba	3 lispanic Origin? (S	pecify Yes or No		1. Race - Ame	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ξ.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		1 □ Yes 2 ⊠ No		to nicari, etc.)	1	Black, Whit	e, etc. BLACK
2-0	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kind	d of Business/	/Industry
21	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done of DO NOT use retired	1)	g	т		7
7	iled w Hygiel ther th	S	12th 17. Father's Name (First, Middle, Last)		PRI	NIER	18 Mother's Nar	me (First, Middle,		PRIVATE	<u> </u>
ano	d be f ental l ced of	To Be	BAKER A. WASHIN	IGTON			ANNA	BRISCOE			
Maryland	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	ř	19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	er, City or	Town, State, 2	Zip Code)
	s 1 and 2 of Health a item 27 is		DOROTHY LYLES/S	SISTER	1105	ALVERTON	STREET	CAPITOL	HEIGH	HTS,MAF	RYLAND 20743
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crei	sition (Name of matory or other plac	ce)	Date	20c. Loca	ation - City or	Town, State
Ë	Pages tment of h tant: If ite		4 ☐ Donation 5 ☐ Other (Specify)	RI		CTION CEM					ARYLAND
Bai	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service License	Leich	22	2. Name and Addre					ERAL HOME ND 20785
		(23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	H	Immediate Cause (Final disease or condition resulting in death)	STAGE IV P	ULMONA	RY SARCO	DOSIS				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq							
		ē	Sequentially fist conditions, if any, leading to immediate	CHRONIC CO Due to (or as a conseq		VE CARDIO	OMYOPATHY	2			
	uted d ansit	Examiner	Gequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	cate be executed oblysician and the burial-transit	dical	ď	l							
9	ertifica ling pl	Med	IF FEMALE:							Victor/2009	11 22
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	aldeath 3[Ectopic pregnancy Other (specify)	/		23	3d. Date of de Month	livery Day Year
P.0.	that the de ned by the a detached f	Phys	9 Unknown					OO- Dida			
	ires the signed	by	Part II. Other significant conditions cor	ntributing to death but not res	uiting in the u	nderlying cause giv	en in Part I.			e contribute to	o the cause of death?
Ö	w requires that s been signed t should be deta	Completed	HYPERTENSION								
Rec	has law	mpl						24a. Was autop perfo		prior to death?	utopsy findings available completion of cause of
ā			25. Was case referred to medical				26 Plans of Do	1□ Yes ath (Check only o	2 🔀 No	1 □ Yes	\$ 2 €□ No
>	/sicia s cert directo	To Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	or	Home 520 Resi		□Other (Spe	ecify)
0	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor		28d. Describe			,,
<u>Si</u>	endir sath. or: Af he fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2 □ No				
Division or Vital Records,	or Attendatter death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Special		reet, factory, office		28f. Location (City or To		Number or R	ural Route Number,
_	Hospital 4 hours Funeral tely filled	Medical Co		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 2 To the complet	Me	29b. Signatule and title of certifier	0		29c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)
	7		Nobest H. X	raid MD		D0555	522		APRI	L 9, 2	800
0	(10)		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type,	Print)					
C	- W		ROBERT H. GERARD			T GLEN RO	DAD SILVI	ER SPRIN	G, MA	RYLAND	20910
100	Sta Registi		31. Date filed (Month, Day, Year) ADD 1 0 2008	32. Registrar's Signa	ature	,					
DH	MH 17 Rev 1/2	-	APR 1 0 2008	COMPAS JO /							

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				partment of Health and Men		2111128 1 5 5 5 5 5
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N	3. Time of Death
1	Physici		JAMES WORDEN YANCEY			Year 2008 4:53 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
4	LXAIIIII	e.	Brooke Grove Nursing Home	Sandy Spring	ì	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. [Date of Birth Month, Day, Yea	9 Birthplace (State or Foreign
ú	Director		078-01-8812 №M 2□F 91 Yrs.		ne 17,	1916 Virginia
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	Maryl f sho	tor	MD Montgomery Silver	Spring		1 ☐ Yes 2 💢 No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. 0	Ditizen of What Country?
	th with	Funeral Director	14208 Royal Forest Lane	20904	Į	JSA
	ems er mu	ıner	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes ﷺ Specify:		Specify: Black
Ö	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	q pa		cedent's Usual Occupation	16b.	Kind of Business/Industry
7.	in 72 n "na Medic	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of working DO NOT use retired)		, , , , , , , , , , , , , , , , , , ,
212	d with giene ir tha	mo	Elementary/Secondary (0-12) College (1-4or 5+) 5 + Den	tist	Se]	lf-Employed
g	al Hy I othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir		
<u>S</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturat", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To	J. Worden Yancey	Mary E.	Brando	n
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic			ailing Address <i>(Street and Number or Rural Ro</i> 8 Royal Forest La:		
e,	s 1 and 2 soft Health and Item 27 Is		20a Method of Disposition 20h Place of Dis	sposition (Name of Date		Location - City or Town, State
Baltimore,	Pages nent of P ant: If Ite any or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mefrop C 4 ☐ Donation 5 ☐ Other (Specify)	rematory or other place)		exandria, VA
Ħ	permit. Pages Department of Important: If It any injury or once.	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Gree		
ñ	perr Dep any		melson & Greeney 8	14 Franklin StA		
-			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between
	Physician	i a	Immediate Cause (Final disease or condition Arterioscleroti	c Cardiovascular		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		210000	
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	ted nsit	Examiner	Sequentially list conditions, and the last sequence of the last sequence			
<u>,</u>	be executed ician and burial-transit	Еха	resulting in death) Last C. Due to (or as a consequence of):			
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89	The law requires that the death certificat tte has been signed by the attending phyage 2 should be detached for use as th	Med	IF FEMALE:			
õ	ath ce ttendi or use	lan/I	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
Vital Records, P.O. Box	he de the a	by Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
۳.	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	w requires that the de been signed by the s should be detached	d b	Endstage Kidney Disease		1 🗌 Yes	2 No 3 Probably 4 Unknown
Ö	aw rec s beer 2 shou	lete	Anemia, Hypertension		24a. Was an	24b. Were autopsy findings available
R	Physiclan: The lav r this certificate has ral director, page 2	Completed			autopsy performed 1☐ Yes 2 🔼	
<u>ta</u>	stan: ertifica ctor, g	BeC	25. Was case referred to medical examiner?	26. Place of Death (Ch	neck only one)	
<u> </u>	hysic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		5 ☐ Residence	6 □Other (Specify)
Division or	ulor Attending Physiclan: effer death. I Director: Affer this certifica d in by the funeral director, i	:uoi	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1 Manual 5 □ Pending (Month, Day Year)	e of 28c. Injury at 28d. y Work? M 1 ☐ Yes 2 ☐ No	Describe how in	njury occurred
S	death death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm,		Location (Street	and Number or Rural Route Number,
È	effer I Dire	Certification:	4 Homicide determined 208. Flace of injury Arthorite, family building, etc. (Specify)		City or Town, St	
	ospita hours unera	Sal	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/o			
	To the Hospital or within 24 hours effe To the Funeral Dir ompletely filled in	Medical	one) and manner stated.	29c. License number		
	T Local	-	29b. Signature and title of certifier	D53367		Date signed <i>(Month, Day, Year)</i>
0	(10)		30. Name and address of person who completed cause of death (Item 23a) (Typ			7/00/2000
C			Rahan Shyamsundar, 9801 Georgi	la AveSte.117 Silv	erspri	ng, MD 20902
	Sta		31. Date filed (Month, Day, Year) APR 0.9 2008			
	Registr	ar	APR 0.9 2008			

DHMH 17 Rev 1/2001

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			For State Registrar	State of	Marylan				lealth a Death		lental Hy	giene Reg. No.	200	8	13	369
7	Dhusisi		Decedent's Name (First, Middle, La	ast)							2. Date of De		/a a a Ye	ar	3. Time of	Death
	Physicia /Medic			din							Apri1		2008		4:15	а м
	Examin	er	4a. Facility Name (If not institution, given 3330 N. Leisure W.			4	1 '		r Location o				County of E		,	
	Funeral				7. Age (In yrs. i		If Unde	er 1 Year	If Under	24 Hrs.		rth		Birthpl	ace (State o	r Foreign
L	Funeral Director			1 X M 2□ F	89	Yrs.	Months	Days	Hours	Min.	Month, Da Dec. 18		18	Couint NY	ry)	
h	pu ,		Usual Residence of Decedent		10c Cib	y, Town or Lo	ocation							10	d. Inside Ci	ty Limite
	laryla shov	or	10a. State 10b. County	.m.o. W.T.		ilver		no							t y⊡Yes	•
	the N 28a-f notifie	Director	Md. Montgo	мету	5	TIVEL		ip Code			-	10g. Citi	izen of Wha	t Count	ry?	
	3a or st be	<u>I</u>	3330 N. Leisure V	orld B1	vd. #90	4	2	0906				U	S			
	be filed within 72 hours after death with the Maryland the Hyglene. A bylyglene dother than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13.	Was Dec	edent of H	lispanic Or an, Mexica	rigin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - /			
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5-0036	hours tural" al Exa	q pe	3 ☐ Widowed 4 ☐ Divorced 15, Decedent's E		ates:WWLL	16a. Dece	dent's Us	ual Occur	ation			16b. Ki	ind of Busin	ess/Ind	ustrv	
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פ	e la la 8	Be	17. Father's Name (First, Middle, Las								e (First, Middle		Surname)			
yla	2 should be filed and Mental Hygi is marked other aumatic event, ti	2	Isador	Zeldin	<u> </u>	T		i	Dorot		Kaufman		- O		2 ()	
	es 1 and 2 should to thealth and Ment fitem 27 is marked rother traumatic		19a. Informant's Name/Relationship Helen H. Zeldin/								rai Route Numi Blvd •				pring	Md.
	tem 27 i		20a. Method of Disposition		20b. F	Place of Dispe	osition (N	ame of			Date	т	ocation - City		<u> </u>	0906
ē			1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		State Nat	emetery, cre	Cren	nator	y 04	/10/	'08	Fal1	Ls Chu	rch	, Va.	
altimore,	permit. Pag Department Important: I any injury o		21. Signature of Fureral Service Lice		10	2	2. Name	and Addre	ss of Facili	ity	-1 D:-	Parking -	109	1 R	ockvi.	11e
m	S II De	L W	1 de			P	ike F	la sa Rockv	ille,	Md.	al Dire 20852	ectic	on			
Ь			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	nplications that c y one cause on e	aused the deat ach line.	h. Do not en	ter the me	ode of dyir	ng, such as	s cardiac	or respiratory	arrest,			Approximat Interval Bet Onset and	e ween Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	static		noma	of t	he Lu	ng .					2 Year	
	/Medical Examiner		Tooding in goalin,	Due to (or as a conseq	uence of):										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):								+		
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,092	ate be executed hysician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):										
∞	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	dical		d										-		
9 ×	death certific attending p	Physician/Med	IF FEMALE:	23c. If yes, out	come pf pregna	ancv							23d. Date o	f dolivo	n/	
Box	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live b	oirth 2 🗆 Feta nant at time of d	aldeath 3	□Ectopic □ Other (pregnanc specify) _	у				Month			Year
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Records,	w require been sign										1	Yes 2	No 3[_ Prob	ably 4 □	Unknown
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<u>e</u>	Attending r death. ector: After by the fune	ation	1 Matural 5 Pending 2 Accident investigation		th, Day Year)	Injury	M		rk?]Yes 2. []No						
Division or	or Attending Physician: The lifer death. Director: After this certificate ha in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 20e. Flace	of injury - At he	ome, farm, st	treet, fact	ory, office			28f. Location City or To	(Street ar	nd Number (e)	or Rura	l Route Nur	nber,
	urs of strain of		00- 0-455-c 4 T 5 -11 -	Neverlation: To 1	hant of multi-	nulodes de	th cos	ad no st	imo det	and al	and due to "	0.000=/) and		totad.	
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	Sta Regist		31. Date filed (Month, Day, Year)	The state of the s	Registrar's Signa	L Go	anti	9								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Warren E. Burch, Jr. April 22 2008 6:00 p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 3km 2 □ F Months Days Hours Director 214-30-6668 74 Oct 5, 1933 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show the Modical Exprimer must be notified at 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2√ No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Homevale Court death 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 □XYes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 TNo Specify Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lt MD State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Warren E. ပ Burch, Mildred Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois A. Burch 404 Homevale Court Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 4/26/08 Upperco, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD ans 21136 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. ENOSTAGE CHAONIC OBSTRUCTIVE /Medical Due to (or as a consequence of) Examiner DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day signed by the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 1 ☐ Yes 2 ☑ No 2 11No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient မှ 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 23,2008 H45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO 25 MMN STREET REISTENSTOWN MD Doborah 31. Date filed (Month, Day, Year) State APR 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Reg. No.
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 64 Year **Physician** Bagley Lee Koy 8:30A M 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ikesville Streamwood Drive Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 219.30.3920 1**№** M 2□ F Months Days Hours Min. Director 07/18/1933 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at MD Baltimore Pikesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Streamwood Drive USA 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 13 acc Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Driver 12th grade 17. Father's Name First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) To Be 2 should be fi Paul Bagley E. Duise Tenni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s Felicia A. Bagley/Daughter 8117 Streamwood Drive Pikesville Health em 27 i MD 21208 Baltimore, 20a. Method of Disposition

Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₽ Important: If it any injury or o Baltimore, MD Loudon 04 25/08 Park 4 □ Donation 5 □ Service Licensee 22. Name and Address of Facility Vaugn C. Greene Fungal SVO 8728 Liberty Road Randallstown MD 21133 23a. Part1. Enter the obsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the net munths Calibblastoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for his is nonsecuence of Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the SE attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Was an autopsy this certificate 1□ Yes Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5XResidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L the Hospital 1's Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Manshall A. Levine istel North Chanles St Tewson) 32. Regetrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Berger <u>April</u> 19,2008 2:35 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing Home Queen Annes Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□M 2□F 22, 1913 Feb. Maryland 217-62-3354 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Queen Annes Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 239 River Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora Mae Colburn John Joseph Easter 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma L. Wright (Wife) 239 River Rd., Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery | 4/24/08 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Alsheimer3 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 20 No 1 ☐ Yes 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No

Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit signed by the attending physicien and does detached for use es the burial-tran Division of Vital Records, P.O. Box 68760, cete hes been signated by page 2 should b this certificate has After this certification funeral director, I death. within 24 hours efter death To the Funeral Director: filled in by the

Physician

/Medical

Examiner

10a. State

Directo

Completed by Funeral

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Examiner

Physician/Medical

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Completed

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Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 le marked other then "natural", or iteme 23a or 28a-f ehow eny injury or other treumatic event. The Medical Examinar must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Was case examine? 25. Was case referred to medical 27. Manner of Death Natural 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) af certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick W. Delboy, M.D., 6602 Church Hill Rd., Chestertown, MD. 21620 forte 2 4 2008 Registrates Signature 31. Date filed (Month, Day, Year)

State Registrar 08-03039 Karol Boracki Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Karol Boracki State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death 0421 hrs Medical Examiner KAROL THOMAS BORACKI April 19, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1827 Fleet Street Baltimore 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) MD Months Days Min. Director Hours 219-50-6523 1 X M 2 08/04/1948 59 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No s 23a or 28a-f show e notified at once. or 28a-f show MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1827 FLEET STREET 21231 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, items Armed Forces? White, etc. 1 Never Married 2 Married 5 Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygeines
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Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SYSTEMS MANAGER 3 SPRINT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) JOSEPHINE PHILLIPS Be CHARLES BORACKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH BORACKI/ BROTHER FLEET STREET, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 ST STANISLAUS CEM 4/22/08 |BALTIMORE, MARYLAND 4 Donation 5 Other Specify: 22 Name and Address of Eachily ER INC. FUNERAL HOME 21. Signature of Fund Service Licenses 1901 EASTERN AVENUE, BALIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Complications of chronic alcoholism Immediate Cause (Final disease xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and trane The law requires that the death certificate be executed Physician/Medical X UNPENDED ##532,27,perME,g879 signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of r this certificate has b al director, page 2 sh performed? death? Yes 2 No 1 🗸 Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 ✓ Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural neral Director: Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) To the Hospital o within 24 hours af determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signatu State 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Jonth** Year **Physician** 09:25 AM 2008 Apri /Medical Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Battin JOHN'S HOPKINS BAYVIEW CARE timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea JAN 3, 19 5. Social Security Number Birthplace Country) (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Hours 218-30-6923 72 Yrs 1936 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1.□Yes 2□No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 HORNEL ST. 21224 UNITED STATES Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CAROLINE BAIER ၉ MICHAEL BINKO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE T. BINKO/WIFE 413 HORNEL ST., BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State □Donation 5 □ Other (Specify) OAK LAWN CEMETERY 4/23/08 BALTIMORE, MARYLAND 21. Si eral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 lease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death or hea Immediate Cause (Final disease or condition resulting in death) **Physician** month Ru /Medical onsequence of): Examiner emor non Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and suit burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ttending physician Physician/Medical IF FEMALE: ns 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the ∣□Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy performed? Yes 2 No Yes or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 20 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the Hospital

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who con

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ed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

29c. License number

Thins

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Year) 1 □ M 2 X F Min Director 56 MD 213-56-5059 Mar 15, 1952 Usual Residence of Decedent the Maryland r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Woodstock MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 1 ury or other traumatic event, the Medical Examiner must be r 21163 U.S.A. Completed by Funeral 10716 Davis Ave 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary (Secondary (0-12) College (1-4or 5+) District Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Forence Strother Leonard J. Dearstine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Burke Spouse 10716 Davis Ave Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Apr 21, 2008 Baltimore, MD **Bayyiew Crematory** e Li ense 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Ener the disease, or complications that caused it shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final cancer **Physician** disease or condition resulting in death) etax /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 █ No 4☐Pregnant at time of death 5 Other (specify) P.O. has been signed by the getached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No perform After this certificate 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 NO P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62254

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W BEVEDERE ALE, BALTIMORE, MB 21215 CRISTINA TRUICA MA 31. Date filed (Month, Day, Year)

State Registrar

APR 24 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 50 2008 Z 0 /Medical Hori 4c. County or Dem...

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Simplification (Stake) County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01 Cross Spring If Under 24 Hrs. tos pita 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Year) -42941 Months Days Hours 1 NM 2 □ F Yrs Director September 18,1940 Washington Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at 10nt gomer 1 ☐Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 6 # 315 20814 items 23a SA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify Completed by Black 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Med Elementary/Secondary (0-12) College (1-4or 5+) Belcan Mail ROOM Supervisor 77 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlington item 27 i Craddock-Brother Frederick Virginia 22204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Pleasant Valley Memorial Park Annandale Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Chinn Funeral Service 2605 S. Shirlington Read Artington, Va 22200 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Days /Medical Due to (or as a consequence of Examiner Chronic Vears Sequentially list conditions, if any, leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ending physician and use as the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2□ No 3 Probably page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: rector, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient funeral dir 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) -32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9801 Georgia Ave , \$220 Silver Spring, MD 20902

Registrar

State

31. Date filed (Month, Day, Year)

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2008

Registrar

Yorke

APR 2 4 2008

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NW Hospital 5401 Old Court Rd. Randullstown MD 21133

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			For State Registrar	State o	of Marylar		artmen rtificate			and Me		giene Reg. No.	UUU	133/8
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	Examir		4a. Facility Name (If not institution		mber)				Location o	f Death	•	4c.	County of Dea	
			Genesis Cron		~ A . //	1	If Under	100,1	lf Under 2	24 Hec. 1			Balto	
	Funeral Director		5. Social Security Number 058-01-5841	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 93	Yrs.		Days	Hours	Min.	B. Date of Birt (Month, Da) 2/7/19	/, Year)	9. Bir	thplace (State or Foreign ountry) NY
	pu ,		Usual Residence of Decedent 10a, State 10b, Count		100 Ci	ty, Town or Lo	nation.							10d. Inside City Limits
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Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ABurial 2 Cremation		State 20b. I	Place of Dispo	natory or of	ne of ther place	MEM! I	Da			cation - City or	
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	To ti Withi To ti comp	Ž	29b. Signature and title of certific				29c	. License	number			29d. Dat	e signed (Mon	th, Day, Year)
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	3		30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)	720	2 70	w5v-	nd	_ 2	11204	
	Sta	ate	31. Date filed (Month Pay Year	2008	Registrar's Sign	ature	. 20 .							

Collins, IRENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** 2:38 PM Zelma May Delahanty /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Randallstown Seasons Hospice - Northwest Hosp. **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days 1□M 2X F Country) Virginia 90 1917 213-54-4860 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene.
Important: If item 27 is marked ofher than "natural", or items 23a or 28a-f show any inJury or other traumatic event, in Markel Ezni. MD N/A Baltimore X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 South Woodington Road 21229 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 📉 No Specify: White Specify 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Posev Even A. Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Maple Avenue, Arbutus, MD 21227 Mary Catherine Delahanty-Dau. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Baltimore on actional 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-23-2008 Baltimore, Maryland 4 Donation 5 Other (Specify)
Signature of Full all Service Lice se Cemetery 2. Name and Address of Facility Amorose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Doobt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Intracranial 61660 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hemmor ka sic Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial P.O. Box 68760, pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 2 No certificate 1 ☐Yes 2 ₺No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 19th 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RECSTENSTOWN MD 25 MAIN STREET

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0330AM April 21 2003 ilie DOCKINS /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manland 8. Date of Birth (Month, Day, Year)

Jun. 25, 1912 Birthplace (State or Foreign Country) **Funeral** Days 96 Director 214-01-1126 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Baltimore Director Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1317 Poplar Avenue 21227 United States Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Henry Ackermann Ottilie Weiblinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Silseth - Daughter 1156 Elm Road, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 12 Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 4-24-2008 Baltimore, MD 22. Name and Address of Facilian brose Funeral Home, Inc. 1328 SUlphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aortic **Physician** valve /Medical Due to (or as a consequence of) Examiner troke Sequentially list conditions, if a price and good in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 0 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 (Month, Day Year) 1 Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

the Hospital or Attending Physician; 24 hours after death. within 2 2

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

egistrar's Signature

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

weene street Balto, MD

2008

08-03100 Michael Ellerbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 338 |

Chael Ellerbe		or State	te or iviaryie	Cer	tificate of	Death				Reg. No.			(5.11)
Physician/ e Examine	1.	Decedent's Name (First, Middle Michael	Ellerbe					I 1	Date of De Month pril 21,	Day	Year	3	Time of Death 1242 hrs
Examine		. Facility Name (if not institution	, give street and nu	mber)	4	b. City, Town, Baltimore	or Location of	Death		4c	. County of	Death	
	Ļ	University Hospital Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ear If Under	24Hrs. 8	. Date of E	Birth (MM/	DD/YYYY)	9. Birth Foreign	place (State or
Funeral Director	3.	Coolar Coolari, Tanaca	1XXM 2 F	24	Yrs		ays Hours	Min.	Oct. 2	, 198	3	Cour	ntry) MD
>	_	sual Residence of Decedent 10b. County		10c. City	, Town or Locati	on							10d. Inside City Limits
d how any		MD No. South				Baltimor	'e						1 XX Yes 2 No
to 28a-f show	1	De. Street and Number 2506 Marbourne	Arromino			10f. Zip Code	21230			109. Citi	izen of Wh. USA	at Count	ry?
ith the last the last the last the last the last last last last last last last last		1. Marital Status		cedent Ever in U	J.S. 13. Wa	s Decedent of	Hispanic Orig	in? (Speci	fy Yes or I	No-			an Indian, Black,
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiere. 127 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 23a nor 28a-f she marked other than "natural", or items 23a nor 28a-f she marked other than "natural", or items 23a nor 28a-f she marked other than "natural", or items 25a nor 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or 28a-f she marked other than "natural", or items 25a or		XXNever Married 2 Ma	rried Armed F	orces?	lf Y	es, specify Cut		, Pueno Rio	an, etc.)		Specify:	Blac	ek
rs after ural", miner	<u>-</u> 2	Widowed 4 Diversity Divers	or Dates:		16a. Deceder	nt's Usual Occu	pation (Give	kind of wor	k done	16b.	Kind of Bu	siness/Ir	ndustry
72 hour n "nati	ompieted	Elementary/Secondary (0-12)		(1-4 or 5+)		cabinetry		use retired)	,	abinet	COM	oanv
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		11 7. Father's Name (First, Middle,	Last)		<u> </u>			's Name (F	irst, Middle	e, Maider	n Surname)	
215-	e l	I.	Michael R.	Ellerbe			<u> </u>						Collins Zin Code)
21 should and Mer is mar	o l 1	9a. Informant's Name/Relations Antoinette Clooins	hip (Type, Print) Mother		19b. Mailin 2506 M	g Address (S arbourne	Avenue;	Balti	more,	Mary]	Land 2	21230	
7 7 8 8 7		20a. Method of Disposition			Place of Dispo		cemetery,		Date				Town, State
More Pages 1 ent of 1 nt: If	- 1	1 XX Burial 2 Cremation 4 Donation 5 Other S		from State A	rbutus Me	morial Pa			/2008		altimor Home,		aryland
Baltimore, permit. Pages I an Department of He Important: If ite injury or other ti	1	21. Signature of Funeral Service	Licensee		22. 6	Name and Add	ress of Facilit Lmor Str						
Physician	+	23a. Part I. Enter the disease, or	complications that	caused the dea	th. Do not enter	the mode of dy	ing, such as	cardiac or r	espiratory	arrest, s	hock, or he	eart	Approximate Interval Between Onset and
1-oical _xaminer		failure. List only one cause Immediate Cause (Final disease	a. Multiple C	Sunshot Wo								_	Death
_xammo.	- 1	or condition resulting in death)	Due to (or as	a consequence	e of):								
* *	<u>=</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	e of):								
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760, cate be exe physician a		IF FEMALE: 23b. Was decedent pregnant in		s, outcome of pr		etal death	3 Ector	oic pregnan	ıcy		23d. Date of Month		y Day Year
Box 687 e death certific the attending p	Physician/	past 12 months?	4 Pre	e birth egnant at time of		Other (Specify)				- {			
. Bo. the deat y the at	Phys	1 Yes 2 No 9 Ur Part II. Other significant cond		known g to death but no	ot resulting in the	e underlying ca	use given in l	Part I.					the cause of death?
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rds,	Completed									Was an autopsy performer		, were a prior to death?	utopsy findings available completion of cause of
Reco	Ë						Place of Dea	h (Chael: s	1	res 2		1 🗸 `	res 2 No
ician: s certifi	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	✓ ER/Outpatie		Other		g Home	5 Res	sidence 6	Oth	er:
Division of Vital Records, P.O. real or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	n: To	1 Yes 2 No 27. Manner of Death	28a. D	ate of Injury onth, Day Year) 21, 2008	28b. Time o	of Injury 280	Injury at Wo		28d. Desc Subject		injury occi not	urred	
Sion Mttendi death. ector: /	Certification:	2 Accident Inv	estigation 28e. F		At home, farm, s			etc.	28f. Local	tion (Stre	et and Nur	nber or F	Rural Route Number, City
Divi	ertifi	4 Homicide de	termined (Spec	ify) Local S	treet					_		_	t, Baltimore , MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil		29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the caminer: On the ba	sis of examination	vledge, death oc on and/or investi	curred at the ti	me, date and pinion, death	place, and occurred a	due to the it the time,	cause(s date and	and mani place, and	ner as st d due to	ated. the cause(s)
To t com	Medical	29b. Signature and title of certi	and mann	er stated.		29c. l	icense numb			2	9d. Date si	gned (A	fonth, Day, Year)
		Paracti Free	thall, M	(1)			D.C.M.E.				April 22,	2008	
3		30. Name and address of pers Pamela E. Southall,		cause of death (ant Medical E	item 23a) Examiner	111 Penn 9	Street, Bal	timore, N	MD 2120	01			
	ate	District Control		gletrar's Sig	nature A	andi)							
Regis		APK Z	4 7000	AT MELAS	ORIGI	NAL				OGME	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Vear **Physician** zabeth 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia

der i Year | If Under 24 Hrs. | 8. Date of Birth
Ins Days | Hours | Min. | Nov. 30, 1929 Howard County General Hospital Howard Age (In yrs. last birthday)
78 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√2 F Maryland 214-24-8302 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at MD Howard Elkridge 1 ☐ Yes 2√2 No **Funeral Director** 10e. Street and Number 6609 Ulm Place 10f. Zip Code 10g. Citizen of What Country? 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restuarant Manager/Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis G. Lockett Helen R. Wingate 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Fugate - Husband 6609 Ulm Place, ELkridge, MD 21075 20b. Place of Disposition (Name of Wastry, Arrange Legiter place) 20a. Method of Disposition 20c. Location - City or Town, State ☑Burial 2 🛱 Cremation 3 🗆 Removal from State 4-24-2008 5 ☐ Other (Specify) Odenton, MD 4 Donation Crematory 4-24-2000 American, 112
22. Name and Address of Facility American Funeral Home, Inc. ure of Funeral Sarvice 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic **Physician** /Medical Due to (or as consequence of): **Examiner** OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an to un autopsy perform 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Major of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVATERIA ro CAKMEN MD 31. Date filed (Month, Day, Year) Begistrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** FLEMING DNE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REHABILITATION EXTENDED CARE BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1931 Days Hours $JUN^{th}, 21^{y}$ 225-36-3619 Virginia Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Rosedale Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21237 1431 Rosewick Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1½ Yes 2 □ No If Yes, Give Year or Dates: 51-54 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important; if item 27 is marked other than any injury or other traumatic. Self-Employed Fire Insurance Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Rose Leafy Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1721 Campbell Road, Forest Hill, MD Michael Fleming - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/23/2008 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams ²²Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APKIL 23 2008 smeller

15 x1

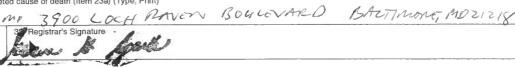
31. Date filed (Month, Day, Year)

THOMAS S

APR 2.4 2008

MILLER,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland / [ment of H		and Me	-	/	08	13384
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		001111	10010 01 2		2.	Date of Dea	th		3. Time of Death
	Physici	an								Month	Day 2008	Year	10:56 P M
	/Medic		Jane Ann 4a. Facility Name (If not institution, gi	Florian	•)	4	b. City, Town, or	Location o		vhrit 5	4c. County	of Death	10:36 P
	Examin	er	Greater Baltimo					200410110	or Dougr		1		
	Funeral				ge (In yrs. last bir		Towson f Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth	Balti		lace (State or Foreign
	Funeral Director			1□M 2 X F			tonths Days	Hours	Min.	(Month, Day	, Year) 13,1952	Cour	otry) vland
4.	_		Usual Residence of Decedent		50					iai cir i	23,1732	1141	y tunu
	ylanc ylanc		10a. State 10b. County		10c. City, Tow	n or Locati	ion					1	0d. Inside City Limits
	a-f sl	호	Maryland Princ	e Georges	E	Belts	ville						1 □Yes 2X No
	nr 28	Director	10e. Street and Number				10f. Zip Code		-	1	10g. Citizen of V	Vhat Cour	ntry?
	th wil		13211 Ingleside	Drive			20	0705			U	SA	
	dea ems	Funeral	11. Marital Status	12. Was Deceden Armed Forces		13. Was	s Decedent of Hi es, specify Cuba	ispanic Orig	gin? (Specif	y Yes or No-	14. Raci	e - Americ k, White,	an Indian,
9	after or ite		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🔯			Yes 21 <mark>57</mark> No	Specify:	i, i delle ille	an, cto.)			etc.
93	ours iral", Exa	d by	3 Widowed 4 Divorced	Year or Dates:		, ,	X	ореслу.			Specify	Whit	:e
21215-0036	within 72 hours after death with the Maryland ene. Than "hatural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's 8 (Specify only highest g		16a.	. Decedent (Give kind	t's Usual Occupa d of work done o NOT use retired	ation during most	t of working		16b. Kind of Bu	siness/Ind	dustry
21	ithin ne. han '	臣	Elementary/Secondary (0-12)	College (1-4or									
N	led w lygie her tl nt, th		12	n/a	Co	ompan:	ion-Nurs				Care-0		ıg
Ē	be fil Ital H Id otl	Be	17. Father's Name (First, Middle, Las						_ `		Maiden Surnam	ie)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Healinh and Mental Hygiene at the firen 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은		Florian, S				Mary			entz		
Jar	l 2 sh n and r is n		19a. Informant's Name/Relationship				Address (Street &						
<u> </u>	1 and 2 Health em 27 i	П	Mary L. Zickler 20a. Method of Disposition	/Mother	20h Place of	H Ra	ylon Dri	ive,	Baltin Date		Marylane 20c. Location -		.236
. 0	iges it of h		1 ☐ Burial 2 🎇 Cremation 3		cemete	ry, cremat	on (Name of ory or other plac	1				•	
<u></u>	t. Pa tmer tant: tant:		4 □ Donation 5 □ Other (Spec	7)000	Metro	-			4/22/0	08	Catonsv	ille,	, Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Sarvice/Lic	Cun		Lei	ame and Addres	neral	Home	of Du	laney Va	alley	Inc.
	40260		Bryan W. Clar		10-1-0-5-	10	W. Pado	onia l	Road,	Timon:	ium, MD	210	193
			23a. Part . Enter t e disease, or con shock, or hear failure. List onl	y one cause on each	line.	not enter t	ne mode or dyin	g, such as	cardiac or r	espiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician		Immediat Com (Final disease or condition resulting in death)	_a. Sep	313							é	2 weeks
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):							
		<u>.</u>	Sequentially list conditions,	b. Abdor	s a consequence	ang	t this	y5 S	08+ +	nssue	infect	ion,	4 LUCEKS
	₹/1/g	ine	Sequentially list conditions, if any, leading to immediate cause. Enter or Jerrying Cause (Disease or injury	Due to (or a	s a consequence	01).							
	and	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit												
387	cate phys the	dical		d									
9 X	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy						004 D-	6 =========	
Вох	atten for us	ä	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 ☐ Fetal death at time of death		ctopic pregnancy ther <i>(specify)</i>					e of delive пth	Day Year
o.	that the de ned by the a detached	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐Unknown	at time of death	300	thei (specify)						
σ.	that t ed by detac		Part II. Other significant conditions	contributing to death	but not resulting in	n the unde	erlying cause give	en in Part I.		23e. Did to	bacco use cont	ribute to t	he cause of death?
Vital Records,	sign d be	d b	Hyperammo	nemi	0					1 U Y	es 2 No	3 ☐ Prob	pably 4 □Unknown
Ö	w requir been si should	etec	THE COMME	11,6						04-11/-			
3e	e law has l je 2 s	Completed								24a. Was a autop	SV I	Were auto prior to co death?	ppsy findings available mpletion of cause of
		S								1□ Yes			2 No
Z.	sician: The certificate hi rector, page	Be	25. Was case referred to medical examiner?	Hospital:			3 DOA Othe	ar.		Check only or			
0	Phys this aldi	2	1 Yes 2 No 27. Manner of Death	28a. Date of In		utpatient Time of	OLI DON I	4 🗆 190			ence 6 Oth		(y)
L	ding Ph After thi funeral	ioi	1 Natural 5 Pending	(Month, D		Injury	28c. Injury Work	yaı ∢? Yes 2. []∣		i. Describe n	ow injury occur	ea	
S	ttend death stor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be 290 Place of in	njury - At home, fa	arm stroot		162 2 1	i	Location /C	trant and Numb	acar Bur	al Route Number.
Division	il or Attend after death I Director: d	Certification:	4 ☐ Homicide determine	building,	etc. (Specify)	arm, street,	, ractory, office		201	City or Tow	n, State)	ei oi nuiz	ar noute ivarriber,
_	pital ours a eral filled		29a, Certifier CertifyIng F	Physician: To the bes	t of my knowledge	e death or	courred at the tin	ne date an	nd place, and	d due to the	cause(s) and ma	inner as s	tated
	24 hc 24 hc Fun etely	Medical		aminer: On the basis and manners	of examination ar								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier				29c. License	e number		- 2	29d. Date signe	d (Month,	Day, Year)
	->-0		no Co	1			7	9			0120	120	08
	0		30. Name and address of person wh	o completed cause of		(Type Prin		90-	1		7100	100	
	4		Marie Chatha	~ 653	5 N.	Char	100 0	+	·R	Itim	(500 5	nin	21204
\$	Sta	te	31 Date filed (Month, Day, Year)	3 Regis	trar's Signature	Anen	61	•		1111/)	010	_ ب	J
7	Registr		APR 242	JUX DECK	as so	Contract of the second							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

u.g u		- For State	or maryiana, 2	Certific	ate of Dea	ath		F	teg. No.	200	
Physicia	n/	edistrar I. Decedent's Name (First, Middle,Last	t)					Date of Dea Month	Day	Year	3. Time of Death 0054 hrs
edical Examir	_	CRAIG O. FREE	ELAND		To an			April 18, :	2008	inty of Death	0054 Hrs
	1	4a. Facility Name (if not institution, give Doctor's Community Hosp				y, Town, or Lo	ocation of De	eatn		e George'	s
		5. Social Security Number 6. Se		yrs. last bir		nder 1 Year	If Under 24	Hrs. 8. Date of B	rth(MM/DD/Y	YYYY 9. Birth	nplace (State or
Funeral Director		, , , , , , , , , , , , , , , , , , , ,			Mo	nths Days		Min	-1964	Foreign	ntryMARYLAND
Birector	ŀ	217-88-9738	(M 2 F	44	Yrs.			J=0	-1304		TIANT DANG
any		Usual Residence of Decedent 10a. State 10b. County	100	City, Town	or Location						10d. Inside City Limits
<u> </u>		MD. PRINCE O	EEORGES	Т	ANHAM						1 Yes 2 XNo
daryland 28a-f show	ま	10e. Street and Number	32011025			Zip Code			10g. Citizen o	of What Coun	try?
th the Maryland 23a or 28a-f sho	Director	9321 FONTANA DE	RIVE			20706	i	i	USA	A	
with t 18 23a		11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec	edent of Hispa	anic Origin?	(Specify Yes or N	o- 14. F	Race - Americ White, etc.	can Indian, Black,
r item	Funeral	1 Never Married 2 X Married	Armed Forces?	No				erto Rican, etc.)			CV
after all", o			If Yes, Give Year or Dates:			2 X No				cify: BLA	
hours		15. Decedent's Education (Specify or		ted) 16a.	Decedent's Us during most of				16b. Kind o	of Business/Ir	naustry
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) -12-	College (1-4 or 5+) -0-		SECURIT	Y OFFI	CER		SI	ECURIT	Y COMPANY
5-0036 iled within 73 Hygiene. I other than the Medical	탕	17. Father's Name (First, Middle, Last))			18	3.Mother's N	ame (First, Middle	, Maiden Surn	name)	
1215-0036 d be filed within 72 fental Hygiene. narked other than '	Bec	MILBON FREELANI					MAR	Y ANN MA	CKALL		_
2121 ould be fil Mental I marked ic event,	P	19a. Informant's Name/Relationship (T		19	9b. Mailing Addi	ess (Street	and Number	or Rural Route N	mber, City or	Town, State,	, Zip Code)
more, MD 2121 Pages 1 and 2 should be freen of Health and Mental nnt: If item 27 is marked		COZETTE FREELAN	ND(WIFE)					VE LANHA			
ore, MC ss 1 and 2 s of Health at If item 27 her traum		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	crema	of Disposition (atory or other pla	ace)	· I	Date		ation - City or	
Pages		4 Doggtion 5 Other Specific									M, MARYLAND
Baltimore, permit. Pages 1 at Department of He Important: If ite	1	21. Signature of Poneral Service Licer	nsee GLADIS A	m	1 / E 1	and Address	of Facility	EWELL FU	NEKAL I	DEDEDI	CK, MARYLAN
E.E. 6		23a. Part I. Enter the disease, or comp	sew								Approximate Interval
Physician Medical		failure. List only one cause on ea	ach line.			de oi dyilig, a	den as card	iac or respiratory c	iroot, oriook,	57 110011	Between Onset and Death
xaminer		Immediate Cause (Final disease a. or condition resulting in death)	Cocaine Intox:								
		h		crice orj.							
	盲	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):							
	Examiner	(Disease or injury that initiated	Due to (or as a consequ	ence of):							
scuted and transit		events resulting in death) Last		,							
760, rate be execut physician and he burial - trat	Medical	X UNPENDED	AMENDED 23a,2	7,28a-f	per ME g	878 4/2	5/08 am	h			
760, icate be ex physician the burial	Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	:y					ate of deliver	
ox 687 eath certific attending for use as t	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tim	ne of death	2 Fetal de		Ectopic p	regnancy	Mo	nth [Day Year
Box 68 e death certifi the attending ed for use as	/sic	1 Yes 2 No 9 Unknow		ic or doda.	5 Other (Specify)					
D. B. t the de by the ached f	Phy	Part II. Other significant conditions	contributing to death b	ut not result	ing in the under	lying cause gi	ven in Part	. 23e. Did			the cause of death?
ires that the signed by the detached	ğ							_ 1 _ `	res 2 N	o 3 Prol	bably 4 🗸 Unknown
rds, requir	ompleted							24a. Wa	as an topsy	24b. Were au	utopsy findings available completion of cause of
e law e has ge 2 sl	d m							pe	rformed?	death?	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should i	O	25. Was case referred to medical				26.Place	of Death (C	heck only one)			
/ita	o Be		Hospital: 1 Inpatient	2 🗸 ER/	Outpatient 3	DOA	Other 1	lursing Home 5	Residence	e 6 Othe	er:
fing Ph After ti funeral	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day,Year		. Time of Injury	1 1	y at Work?	l l	e how injury	occurred	
ion leath.	ţ	1 Natural 5 Pending 2 Accident Investigat	4/17/08	11	L:48p		es 2 X N	UIK			
Division pital or Attendiours after death. teral Director: Affilled in by the fu	ertification:	3 Suicide 6 X Could no	t be 28e. Place of Injur		, farm, street, fa	ctory, office b	uilding, etc.	or Towr	. State)		ural Route Number, City
Spital lours a filled	Cert	4 Homicide determine	(opening Restu								PG Co.,MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physic one) 2 Medical Examine	cian: To the best of my ker:On the basis of examin	nowledge, o	death occurred a or investigation.	at the time, da in my opinion.	ite and place , death occu	e, and due to the corred at the time, da	ause(s) and mate and place,	nanner as star , and due to the	ited. he cause(s)
To the To the Comp	Medical	29b. Signature and title of certifier	and manner stated.			29c. License					onth, Day, Year)
	-	has ha	i mod			O.C.1			April 1	19, 2008	
		30. Name and address of person who	completed source of doc	th (Item 22)	2)						
			Medical Examiner		enn Street, E	altimore, I	MD 2120	1			
S	tate		3 Registrar's		1 0						
Regis		188.24 20	08	AK.	Anoth.	7					
DHMH 17 Rev 1/2	001			Ċ	RIGINAL			OCM	E		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 9:05 AM FEIGLEY 2008 APRIL WINSTON 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE BATVIEW JOHN> HARKINS MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/5/1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Days Hours Months 216-28-4416 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No EASTWOOD MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 7282 BRIDGEWOOD DR 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTERN ELECTRIC CABLE TESTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUTH MARIE KERN WILLIAM HENRY FEIGLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7282 BRIDGEWOOD DR BALTIMORE, MD 21224 19a. Informant's Name/Relationship (Type. Print) MARY FEIGLEY-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/08 OAKLAWN BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Fu eral Service Lice see 22. Name and Address of Facility CHARLES S. ZEILER AND SON 6224 EASTERN AVE BALTIMORE, MD 21224 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE CONGESTIVE Two WEEKS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or Items 23a

"natural"

72 hours after death with

filed within 7 I Hygiene. than

Pages 1 and 2 should be

and Mental Hygie Is marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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traumatic event, the Medical Examiner must be notified

and physician as the l attending for use as page 2 s certificate |

Physician/Medical

law requires that the death certificate be executed this funeral (After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the

Division or Vital Records, P.O. Box 68760,

State Registrar

d by	CARDIAC ARRES	0		given in react.	1 ☐ Yes 2 [□ No 3 □ Probably 4 ⊅ Inknown
Completed	CARDIAC ARRE	Ξ			24a. Was an autopsy performed? 1 Yes 2 1 1 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑No
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 (Manpatient 2 ☐ ER/C	Outpatient 3 DOA	Other	n <i>(Check only one)</i> me 5 ☐ Residence 6	5 □Other (Specify)
ation: T	27. Manner of Death 11 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	o. Time of lnjury M		28d. Describe how injury	
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, o	office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
edical (ysician: To the best of my knowled niner: On the basis of examination a and manner stated.				
ž	29b. Signature and the of certifier		29c. L	icense number	29d. Date	e signed (Month, Day, Year)

29c. License number ZES -000 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN AVENUE MP, PHD

BALTIMORE, MARILAND

MOPHO

29b. Signature and the of certifier

OSTRIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month W. Gamber 15, 2008 Frank April 9:10AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1**X** M 2□ F 80 March 11,1928 215-24-9443 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11212 Thompson Ave. 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🎾 No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tool Maker Ward Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arie Sylvester Gamber Isabell Q. Crunkilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Martin Granddaughter 11212 Thompson Ave., Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4/18/08 Pikesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ber Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Due to (or as a consequence of)

Physician /Medical Examiner

burial-transit

attending physician for use as the buria

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signed t

certificate

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

the Hospital or Attending

and

certificate be executed

Box 68760.

Division or Vital Records, P.O.

Physician

/Medical

Examiner

10a, State

Funeral

Director

28a-f show

23a or pe

7 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must

than

Lep riment of Health and Mental Hy, mp riant: If item 27 is marked other by injury or other traumaticals.

permit. Pages 1 and 2 should be Dep. riment of Health and Mental Imp. rtant: If Item 27 is marked t any injury or other traumatic ev-once.

Maryland 21215-0036

Baltimore,

notified

Director

Funeral

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Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of). Due to (or as a consequence of) 23d. Date of delivery

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknowr Completed

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal

24a. Was an autopsy 1☐ Yes

1 🔲 Yes

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 ☐ Probably 4 ☐ Unknown

Day

Year

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Magner of Death Natural 2 🔲 Accident 3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

031660

STUNER AVENUE

29d. Date signed (Month, Day, Year) 5/2008

WESTMIN STER MANGE

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State Registrar

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Certification:

cal

Media

31. Date filed (Month, Day, Year)

Honts K. APR 24 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TII mo 1PC 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Graham 12:01A M Uphelia Marie 04 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8404 Downey Dale Drive Kandallstown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. A 2 Yrs. Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 216.20.6404 1 ☐ M 2 🗙 F NC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits marked other than "natural"; or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at Baltimore Kandallstown MD 1 □ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dale Drive 8404 Downey 21133 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BOCK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the ttomemaker Private 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland William McClendon Essie M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 S Shellie Graham, Downey Dale Drive Randall stown MD Daughter Department of Health Important: If Item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 04/26/08 Baltimore, MD Arbutus Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral SNCs 21. Signature of Funeral Service Licensee C. Geere Jaklahn -Road Randallstonn MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio myopath disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed attending physician and for use as the burial-train Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @ nknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 1 Tes 2 No 6 ☐Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 Hatural neral Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 750

MD

32. Registrar's Signature

mainst.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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APR 2 4 2008

08-03082

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Ellis Goodson Certificate of Death 1- For State Reg. No. Time of Deati Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 20, 2008 2005 hrs Mer Examiner ELLIS TYLER GUNDEL-GOODSON 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 5656 Stevens Forest Road #145 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Min. Months Hours Country) 7/27/1994 Director 149-96-1395 Yrs 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 XNo COLUMBIA 23a or 28a-f show notified at once. HOWARD MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. rector 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ö 5656 STEVENS FOREST RD. 21045 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No items 23a 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? 1 X Never Married 2 Married Yes 2 X No BLACK Specify: 1 Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed 4 is marked other than "natural", itic event, <u>the Medical Examiner</u> 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 N/A STUDENT 7TH GRADE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GUNDEL NTCOLE Be ELLIS GOODSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 145 COLUMBIA, Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m APT 5656 STEVENS FOREST RD. NICOLE GUNDEL/MOTHER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition MONMOUTH MEMORIAL 1 X Burial 2 Cremation 3 Removal from State 4/26/2008 TINTON FALL, NJ Donation 5 Other Specify: DARK CEMETERY
Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and nysician failure. List only one cause on each line Death ledical a Hanging Immediate Cause (Final disease _xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransit Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Jo Unknown detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 Unknown signed I þ 24b. Were autopsy findings available Completed 24a. Was an s been s prior to completion of cause of autopsy death? performed? this certificate has il director, page 2 sl 1 🗸 Yes 2 No No Yes 2 26.Place of Death (Check only one) E Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: examiner? ER/Outpatient 3 Inpatient 2 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject hanged himself Certification: FOUND: 1 Yes 2 V No Natural Pending Apr 20, 2008 1951 hrs Director: Investigation 28f, Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5656 stevens forest Rd #145, Columbia, MD 3 V Suicide Could not be determined (Specify) Residence To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 21, 2008 O.C.M.E. h 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr. 878 4-24-08 vt. State of Maryland Poeparlment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APR **Physician** 2122 AM Celestine F. Grant 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Baltimore Itospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 2, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 220-18-8475 1 □ M 2 🕟 F 85 NC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If them 27 is marked other than "natural", or them 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Baltimore r 28a-f sh notified 1. No 2 □ No Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ms 23a or 3 2802 Baker Street 21216 USA Funeral Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No **Black** Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) hospital 12 practical nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Campbell ဥ Lula Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne C. Rhone / Daughter 3100 Belmont Avenue; Baltimore, Maryland 21216 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or = 5 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 04/24/2008 Baltimore, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or compiled tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician O Cara disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions Due to for as a consecutional offi-Examiner If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Δ. requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 | Yes 2 | No 3 | Probably 4 | Unknown Record 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No The law 24a. Was an autopsy page perform certificate Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To this 9 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Sargine

31. Date filed (Month, Day, Year)

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ORIGINAL

St. Agnes Hospital Baltimore, Md.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 2008 Green Shaws OU Emmanuel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner County C Howard 7. Age (In yrs. last birthday) General Howard Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Months 1 N/M 2 □ F 04 2002 MP Director none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 □Yes No Completed by Funeral Director Tanove 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21076 SA 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental is marked Shawn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21076 HANOVEY iduxII permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra aurenba 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Horro ld Columbia PI 23a. Part 1. Published is has or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atresia Due to (or as a consequence of **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as \ consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Vear Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 Mo 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No or Attending Physiclan: 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 npatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🖬 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 4059911 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Road #102 21047

DHMH 17 Rev 1/2001

State Registrar

A.

31. Date filed (Month, Day, Year) APR 2 4 2008

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3 Registrar's Signature

Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23e per doc 8878 4-24-08 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 03:05 AM RUTH HOOK APRIL 18 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HARBOR HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 220-18-2633 82 Yrs Mar. 12, Maryland Director Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location
Baltimore 10d. Inside City Limits 10a. State show ns 23a or 28a-f show must be notified at MD 1X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21223 2662 Wilkens Avenue by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or Item Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Iter any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurses Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Louise Shankle William John Clyde Culler ဥ 19a. Informant's Name/Relationship (Type. Print)
Tom DeLoach - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Westchester Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of Meaclewire reference) 20c. Location - City or Town, State Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-2008 5 ☐ Other (Specify) Memorial Park Elkridge, MD A Funeral Service 21. Signalia 12. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS SEPSIS Ph sician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 YAC ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ALTERED MENTAL STATUS The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical EXACERBATION OF PULMONARY CONGESTION SS IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes ♣ No • Probably 4 ☐ Unknown DILATED CARDIOMYOPATHY CONGESTIVE HEART FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has be irector, page 2 s autopsy performed? CHRONIC OBSTRUCTIVE PULLWONARY DISEASE or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No မ funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury within 24 hours atter www...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier 1 🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) APR 2 4 2008

ccan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MP

RESODO

APRIL

18 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** O S FRUPULTE EL MA 846.76 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUR BUN14065 くいっしょうしょうり シャロションプル CVC 2743 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days 212-28-86 1 2 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ZYes 2 No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No þ Specify: 3 ₩ Widowed 4 Divorced er than "natur, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THERADE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ NILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra VIA THOMAS BAL 10 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) OWINGS MILLS MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JR. FUNERAL HOME BROWN FULTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART 201728000 SVINGE. $\omega\omega\omega$ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

WIRR HOR

PUND

30001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

40

32 Registrar's Signature

- RN

31. Date filed (Month, Day,

1. Decedent's Name (First, Middle, Last) **Physician** Melvin A. Hammelman /Medical Examiner Social Security Number Age (In yrs If Under 24 Hrs **Funeral** Hours Days Months 1 M 2 □ F 84 Director 219-16-3702 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Md. Director Balto. Co. Parkville 10e, Street and Number 8800_Walther_Bly Funeral 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g AMNELMAN Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las Be ဂ John C. Hammelma 19a. Informant's Name/Relationship Marianne Faul 20a. Method of Disposition ty Burial 2 □Cremation 3 4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

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1 Yes 2 No 3 Probably 4 Winknown	ant conditions	contributing to death but not resu	alting, in the underlying cause given in Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
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Describe how injury occurred Describe how injury occurred	KNIN			/ 24a Was 5	ande Wee	utonou finaline e e elle la
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Hospital: 11 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at 28c. Inj		,		1□ Yes 2 1 2		s 2 No
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5 ☐ Pending investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	0	1₩Inpatient 2	Ervodipatient 3 BOA 4 Nur			ecify)
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RESOUDD 4/22/08 Stiperson who completed cause of death (Item 23a) (Type, Print) BR GUMBS 9000 FRANKLINSQUARE DRIVE BALLIMSE, and 21237	e of certifier	1	29c. License number	29d.	Date signed (Mon	th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 🙀 ☐ No

08

9. Birthplace Country)

Md

4c. County of Death

2. Date of Death

Date of Birth (Month, Day, Year)

5-5-1923

certificate be executed as the burial-trans physician asn signed by the a d be detached f

Exami

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes

27. May er of Death

2 Accident

(Check only one)

29b. Signature and title of

30. Name and address

3 ☐ Suicide 4 Homicide

29a. Certifier

2 No

2. Registrar's Signature

Other significant conditions

9 🗀 Unknown

page 2 certificate After this death.

Division or Vital Records, P.O. Box 68760

Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Registrar

State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Parkville 0ak<u>crest</u> Balto. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Days Months Hours **№** M 2□ F 86 Director 186-16**-**4787 11-9-1921 Pa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏋 ☐ No Director Md. Balto. Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral 8800 Walther Blvd. 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? tt☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2x ☐ No Specify: Specify: δ 3. ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masters Guidance Counselor Balto. Co. Public Schoo 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be ဥ Edward Hendricks Florence Bednark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hendricks DTR. 8800 Walther Blvd. Parkville, Md.21234 20a. Method of Disposition

♣ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) BelAir Memorial 4-25.2008 BelAir, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner signed by the ettending physician and d be deteched for use es the buriel-transit The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ğ 24b. Were autopsy findings aveilable prior to completion of cause of death? should 24a. Was en eutopsy Completed performed? After this certificete hes funeral director, page 2 1 ☐ Yes 2 400 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide the Hospital of thin 24 hours of the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signateure and title of certifier 29d. Date signed (Month, Dey, Year) 10 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Durmente Bruce mi Day, Year) 2008 31. Date filed (Month, DAP) 2. Registrar's Signature

State Registrar

Division of Vital Records, P.O. Box 68760

			For State	State of Ma	aryland /					nd Me	ental H		2000	Ç	13395
100			1 - State Registrar Certificate of Death Reg. 1. Decedent's Name (First, Middle, Last) 2. Date of Death									Death		ند	3. Time of Death
	Physici /Medi		Mo								Month Apri		, 2008		1:08 P. M
A STATE OF THE PARTY OF THE PAR	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death												
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	Funeral		5. Social Security Number 6 215–16–7942	e (In yrs. last birthday) If Under 1 Year Months Days Yrs.				If Under 24 Hrs. Hours Min.		Date of I	Birth Day, Year	9.1	Counti	ace (State or Foreign	
No.	Director		Usual Residence of Decedent	86 Yrs.					C	ct.	3, IS	921 West Virginia			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		10a. State 10b. County	10c. City, To	10c. City, Town or Location								10	d. Inside City Limits	
		cţo	Maryland N/A Baltimore												1√Yes 2□No
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		Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	3 2 ∏ No		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto				can, etc.)	140-	Black, White, etc.		
036		þ	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No <i>Specity:</i>							Specify: White		
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work							of working	Music Store/MD Bible Society				
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Maryland		To Be	Jacob Hoffm	•					Hatti	,		tema	,		
aryl		ř	19a. Informant's Name/Relationship		19	9b. Mailing	Address (S					Number, City or Town, State, Zip Code)			
			Keith Hoffman	(nephew	7) 2	1224	Mt. A	etna	a Rd.	Hage	ersto	wn, l	Marylar	d 2	21742
ore	of He fitem		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	I □Removal from State	20b. Place	of Disposit	tion (Name atory or othe	of	i	Da			Location - City		
<u>Ë</u>	Pages ment of lant: If its		4 □ Donation 5 □ Other (Spe		Govans	Presb	yteria	n Ch	. Cem.	4-25	-08	Ba	<u>ltimore</u>	, N	Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Li	censee		22. M- 6.	Name and A itchel 500 Yo	Address Ll-W ork	of Facility iedef Road	eld Bal	Fune:	cal H	lome, In	nc.	21212
JIS			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the diselse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between												
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Вох	Physician: The law requires that the death certifica this certificate has been signed by the attending plant director, page 2 should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?	pf pregnancy 2 □ Fetal death 3 □ Ectopic pregnancy t time of death 5 □ Other (specify)							23d. Date of delivery Month Day Year				
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000	ie law requ has been je 2 should	plet									24a. Was an autopsy		24b. Were autopsy findings available prior to completion of cause of		
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Vital	sician: The certificate har rector, page	Be	25. Was case referred to medical examiner?			26. Place of Death (Check only one)									
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	ding Ph n. After th funeral	jon:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury 28b. Time of 28c. Injury at Work? 28h. Dipury M 1 □ Yes 2 □ No					8d. Describe how injury occurred					
Division	or Attencafter death Director; in by the	licat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,									Route Number.			
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To th within To th comp											29d. Date signed (Month, Day, Year)			
			John W.	1 Sive	e mi			Do	106	49		4	1/23	10	8
	10		30. Name and address of person w						,		7	1 00	201		
	l		John W. Bowie, 31. Date filed (Month, Day, Year)		N. Char	rıes	Street	t 1	lowson	n, Ma	ıry1a	na 21	L2U4		
	Sta Registi		APR 24	2008	ar's Signature	A									

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Margaret Marie 2:30 AM April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Baltimore Maris 1 imonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05 10 1940 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 **X**F 219.32.642 Director 0 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road 21239 USA edarcrott by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the May ping. Elementary/Secondary (0-12) College (1-4or 5+) taministrative Assistant 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Warwick Perkins Betti Hairston ပ 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Cedarcroft Road Baltmore MD 21239 Hwband exander Hairston Baltimore, APRIL 18, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Barrison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility C. Greene Funeral SIVGS Vaushn Vallehi 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying the chart allure. List only one cause on each line. Immediate Cause (Final **Physician** a BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exam Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached to 1 ☐ Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certificate has funeral director, page 2 s autopsy 1 □ Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TECTIFY Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 8 m 56 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State BURNE Registrar

2:30

2008

MARGARET HAIRSTON

State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 🔒 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 2:45 A M SALLIE RUTH HARRIS APRIL 18. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE ROSSVILLE ROSEDALE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 1 F 214-24-0494 81 11/23/1926 Director MD Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ıral", or items 23a or 28a-f shov Exaπiner must be notified at 1 X Yes 2 ☐ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 FRAILEY WAY 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year, or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married "natural", or Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 should be filed who and Mental Hygier 15 marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM CONNER IDA MAE FORSYTHE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM WILSON-SON BALTIMORE, MD 21205 943 SPANGLER WAY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Laurial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL 4/23/08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON FUNERAL 21. Signature of Funeral Service Licensee 6224 EASTERN AVE BALTIMORE, MD 21224 HOME, INC 23a. Part: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 20 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1, Natural 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Waldhom Registrar's Signature 31. Date filed (Month, Day, Year) State APR 24 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		rtment of H tificate of I			iene eg. No:200	8 13399		
7			1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat	th	3. Time of Death		
	Physici /Medio		Rosalie E. Imwo					Month 4-20-20				
À.	Examin	er	4a. Facility Name (If not institution, given Oakcrest	e street and number)		Balto	Location of Death		4c. County of I	Lto. Co.		
	Funeral		5. Social Security Number 6. S		If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)				
	Director		219-42-6203	□м 21Ст 88	Yrs.	Months Days	Hours Min.	(Month, Day, 11-21-	1919	Md.		
	and w		Usual Residence of Decedent 10c. City, Town or Location 10d. Inc.									
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	r 28a	Director	10e. Street and Number		ierry n	10f. Zip Code		1	0g. Citizen of Wha	at Country?		
	th witi 23a o 1st be	al D	4243 Cardwell Av	renue		2123	6		USA			
	er dea tems	Funeral	11. Marital Status	12, Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, White, etc.		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3(☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	□Yes 2∏XNo	Specify:		Specify:	White		
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Maryland	l be fi ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Joseph Snyder				18. Mother's Name Margaret		,			
Ě	should nd Me mark matic	2	19a, Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Rura			ate. Zip Code)		
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<u>=</u>	Page ment ant: If ury o		1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	•		ery 4-24	-2008	Balto.N	1d .		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer		22.	Name and Addres	ss of Facility					
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	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	0					Interval Between Onset and Death		
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89	rtificat ng phy as th		IF FEMALE:									
õ	death certifica attending plant of for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnature 1 ☐ Live birth 2 ☐ Feta	al death 3□	Ectopic pregnancy	,		23d. Date o Month			
P.O. Box	he de: the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5□	Other (specify)			Worter	buy Tour		
٦.	ires that the de signed by the a	/ Ph	Part II. Other significant conditions of	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								
Records,	quires n sign ıld be	d by						1 □ Ye	es 2 HO 3[☐ Probably 4 ☐ Unknown		
ပ္သ	aw requir. s been si 2 should I	olete						24a. Was a	n 24b. Wei	re autopsy findings available		
Ä	The lav ate has page 2 s	Completed					···	autops perform	ned? dea	r to completion of cause of th? Yes 2		
Vita	cian: ertific ector,	Be (25. Was case referred to medical examiner?			1	26. Place of Death					
or.	Physician: The la r this certificate has ral director, page 2	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatient 28b. Time of		4 La Nursing Hon		ence 6 Other ((Specify)		
ono	ding Ph h. After th funeral	tion:	1 Matural 5 Pending	(Month, Day Year)	Injury	28c. Injur Worl	yat k? Yes 2∐No	od. Describe no	ow injury occurred			
Division or	Atten r deatl ector: by the	fical	3 Suicide 6 Could not be	28e. Place of injury - At h	ome, farm, stre			8f. Location (St	reet and Number o	or Rural Route Number,		
á	s after or all Director	Certification:	4 Homicide determined	building, etc. (Special	(Y)			City or Town	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a, Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death ation and/or inv	occurred at the tir estigation, in my o	me, date and place, a	and due to the c	ause(s) and manno late and place, and	er as stated. I due to the cause(s)		
	ro the vithin 2 of the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (A	Month, Day, Year)		
}			1			DI	3117		Apr. 1 21	11 200 €		
	6		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, F ンのしれ	0 1	Pakn	1h n	ND 21	2 3 4		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 4 2	32. Pegistrar's Signa	ature	auth a	,		<u>`</u>			
				Branch State of	A TEN							

Inmel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randall DIACLICE'M MOCEN Move 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6 Sex **Funeral** 212-44-0088 1 □ M 2 F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trannatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 Des 2 □ No BAITIMORE Director m.D. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3502 by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ZGRADE POSTAL Employee MAIL W 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lithelmenia 2 Tones VIANA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELISH TANdel Istoun m D 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BA/10. mg 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 110gN. CALOline St alrices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) IDVASCU **Physician** /Medical Due to (or as a consequence of): **Examiner** pertension. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 28e. Did tobacco use contribute to the cause of death? Completed by JC1 Yes 2 No 3 Probably 4 Donknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 21 No completely filled in by the funeral director, 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 00A 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

15

State Registrar 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day April 23, 2008 7:15 am Vernona Irene Jennings 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice - Dove House Westminster Carroll 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 💢 F 9/8/1922 85 488-34**-**7132 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2551 Baltimore Blvd. Trailer # 42 21048 S. A. 12. Was Decedent Ever In U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 Widowed 4 □ Divorced Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Ross Lula Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Robinson (Daughter) 2551 Baltimore Blvd. Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Overlea, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue da Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 XNo 1∐ Yes 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Dove House 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident

Physician /Medical Examiner that the death certificate be executed

once,

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

Show

if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

2 should be filed with and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

Examiner and burial physician Physician/Medical the as for use the þ signed by be det þ Completed has le 2 page certificate ector, Be ဥ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 No

25. Was case referred to medical examiner? 1 Tes

> 5 ☐ Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Westminster, MD 21157

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician;

n 24 hours after death.

Te Funeral Director: A pletely filled in by the fu

within 2

completely

State Registrar

Medical

55 Center 31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year 12:49 AM Johns James April 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthd Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₩ 2□ F 69 Director 219-26-4780 Jan. 4, 1939 NC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 S. Crain Hwy Funeral 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finury or other traumatic event, the Medical Examines. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Boilermaker Heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Johns Esther Lawrence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 S. Crain Hwy., Glen Burnie, MD 21061 Mrs. Jacqueline Johns/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 23, 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation 2008 Stevensville, MD 22. Name and Address of Facility Singleton Funeral and Cremation 21. Signature of Funeral Service Licensee Treduce M01411 1 2nd Ave. SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Physician week /Medical Due to (or as a consequence of): **Examiner** Necrotizing Fasciih's
Due to (or as a consedence of): 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ed by t signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? res 2 No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient ၉ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) ٥ DOO 64635 April 23,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, Maryland Robert S. Stephens MD 22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2008 Month James Johnson April 19, Α. 12:05 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M M 2 □ F Months 219-28-3334 Jun. 5,1932 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3939 Roland Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No 1 ☐ Yes 2121No Specify: Specify: White 3 ☐ Widowed 4X Divorced Korea 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker 6 Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Beck George Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Loud Granddaughter 5109 Goldsboro Drive, Hampton, Virginia 23605 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/21/2008 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Regiratory disease or condition resulting in death) Due to (as a conse mence of) nlmone Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 6hit 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Type II Dinbeter Mellitus 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner Examiner

permit. Pages 1 and 2 a Department of Health a Important; if Item 27 Is any Injury or other trau

Physician

/Medical

Examiner

Directo

Completed by

Be

2

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Physician/Medical

Completed by

Be

၉

Certification:

Medical

The law requires that the death certificate be executed

To the Hospital or Attending Physician;

within 24 hours a To the Funeral I

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a Wasan 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital:

28c. Injury at Work? 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D041476

29d. Date signed (Month, Day, Year) 04.19.2008

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, STE 416 ; BALTIMORE RAYMOND W. WILSON M.D.

31. Date filed (Month, Day, Year) 2 4 2008 32 Registrar's Signature Charles 1

MID.

7

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month lohns Apri 1215 AM 22,2008 headare oseph 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bayriew Medical Conton Hookins 7. Age (In yrs. last birthday) Under 24 Hrs. lours Min. 8. Date of Birth (Month, Day, Year) NoV 3 19 9. Birthplace (State or Foreign Months Hours 1**K**M 2□F Days 212-46-7194 OV ACY/AND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYIMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 220 5. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 COSCINATOR TOWSON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle Last)

Everlasting

22 Name and Address of Facility
105clh N. ZANN
2635. GNKING

3204

101

20b. Place of Disposition (Name of cemetery, crematory or other place)

omplications that caused the death. Do not enter the mode of dying, such as care lac or respiratory arrest only one cause on each line.

3 Ectopic pregnancy

3□ DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

5 ☐ Other (specify)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

APril4, 2008

20c. Location -

EM CT

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

· (

24a. Was an

26. Place of Death (Check only one

Other: 4 Nursing Home

1 ☐ Yes 2 ☐ No

, Baltimore,

autopsy perform

28d. Describe how injury occurred

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Attimire MARY/ANI

Approximate Interval Between Onset and Death

ZIZZO

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

2

Examiner

Physician/Medical

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Completed

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Certification:

Medical

State Registrar IF FEMALE:

odo Informant's Name/Relationship (Type.

1 ■ Burial 2 □ Cremation

Lu

Inter the

shock, or hear vilur Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

Brian Silverman

31. Date filed (Month, Day, Year)

1 ☐ Yes

Manner Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Sepice Licensee

heodore

20a. Method of Disposition

Print)

3 Removal from State

ardiac

FAther.

Due to (or as a consequence of)

Due o (or as a consequence of):

Due to (or as a consequence of):

If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

4□Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Inpatient

Date of Injury (Month, Day Year)

and manner stated.

4940 Eastern

9☐Unknown

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 ☐ Could not be determined

10

Funeral

Director

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician page 2 should peen s

certificate To the Hospital or Attending Physician: After this within 24 hours anter comments to the Funeral Director: Afternational of the funeral pitch of the funeral of th

DHMH 17 Rev 1/2001

Avenue

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month Day **Physician** Margaret C. Johnston April 22, 2008 11:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Quail Run Assisted Living Ctr. Baltimore Co. Parkville 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😾 F 232-26-1721 Director 21,1916 Maryland Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modoal Event instrust be notified at Edgemere 1 ☐ Yes 2 ☑ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 United States Funeral 3205 Lynch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 21 No Specify þ Specify. 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, Itm Media once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unkn. Ethel Grace Brooke ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol L. Gay (Daughter) 3205 Lynch Road Edgemere, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Gdns of Faith Cem. 4/25/2008 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Comary **Physician** dreare /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limited date cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ■ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at the detached for 5 Other (specify) P.0. 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes To the Hospital or Attending Physiclan: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 13010 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signat 31. Date filed (Month, Day, State 10-0-20 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 3406 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 20^{ay} 2008 KLOTZMAN 5:53 P M RITA /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RUXTON OF PIKESVILLE HEALTH CTR. PIKESVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07/16/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD **Funeral** 1 □ M 2 🔏 F 213-16-9411 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [7 SUDBROOK LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 🛣 No WHITE If Yes, Give Year or Dates Specify: \$ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any hijury or other traumatic event, the Medical Exanonee. 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) HARRY GOLDSTINE BESSIE MILLER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WENDY BRAGER / DAUGHTER 5218 WAGON SHED CIRCLE, OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of ANSHEER NORMALE) Or other place) ATTZ CHAIM CONG. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/23/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Partyl. Enter the disease or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immarate Cause (Final ATHEROSCLERO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se mentially list and lines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed thours after nearh and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy certificate 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ 1 ☐ Yes a No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Man of Death Certification; 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural (Month, Day, Year) after death

Director: A 2 Accident 1 ☐ Yes 2 ☐ No ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALD MD 2835 Smith 283 Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

Thinp Octain Lai off	Philip	Gerald	LaFon
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State of Maryland / Department of Health and Mental Hygiene

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Funer Direct		- 1	5. Social Security Number	6. Sex		. Age (In y		(nday)	If Under Months	Days	Hours	Min.				Foreign	
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21215-0036 21216-0036 Under the filed within 7 I Mental Hygiene. marked other than	event,	Be	Ralph L.	LaFon							Clar				Varga		-
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≥ Pd 2 E	other traumatic	-	20a. Method of Disposition	ı – ua	ignter				E. Navarro Place, Aurora, CO Sition (Name of cemetery, Date 20c. Location								
	her t		1 Burial 2 X Crema	ion 3 F	Removal from	n State	crema	tory or othe	r place)		- 1						
imC Page ment	or of		4 Donation 5 Other	Specify:			letro	Crem							Baltin		MD
Baltimo permit. Page Department o	njury	21. Signature of Funeral Service Licensee. Williams							me and A ema t	ddress o 10n	of Eacility SOC1	ety	of M	ary	land, more,	Inc.	
			3a. Part I. Enter the disease, or complications that caused the death. Do not enter the							ede1	rick	Roac	l, Ba	lti	more.	MD	21228 Approximate Interval
hysici. Medic			failure. List only one cau	se on each li	ne.					uyirig, s	ucii as ca	il Qiac oi i	espiratory	arrest	, 511000, 01 110	art	Between Onset and Death
≟xamin	_	ĺ	Immediate Cause (Final disea or condition resulting in death		nplication to (or as a c			Icohol Al	ouse		_						Death
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387 artifica ling p	as th	au/	23b. Was decedent pregnant i past 12 months?		Live bir	th		2 Feta	il death	3	Ectopic	pregnan	су		Month	D	ay Year
Box 68 e death certil	or use	sici	1 Yes 2 No 9	Unknown 6		nt at time	of death	5 Oth	er (Speci	(y)							
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	اھ	[ati		vestigation	28a Place	of Injury	At home	farm, street					28f Locati	on (Str	eet and Num	ner or Rui	al Route Number, City
Division of Vital Records, oppirate or Attending Physician: The law require hours after deal or After this certificate has been simman Director: After this certificate has been si	filled in	Certification:	_ d	ould not be etermined	(Specify)	or injury -	At righte,	iaiii, 5(i eei	, lactory,	onioc bo	mamy, ca			vn, Sta		JO: 07 1 40	arreste rember, only
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To the I	completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainly as stated.									e cause(s)					
ع نِهَ و	COI	ĕ	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								nth, Day, Year)						
			Jan 19 6	4.11	ma					O.C.N	И.E.				April 21, 2	800	
1		-	30. Name and address of per	son who com	oleted cause	e of death	(Item 23a)										
6			Pamela E. Southall		sistant A				Penn S	Street,	, Baltim	ore, M	D 2120	1			
	Sta	ate	31. Date filed (Month, Pay, Ye	^{2r)} 4 200	32.	istrar's Si	gnatu	ADB	A COL								
Re	gist	rar	AFRZ	4 200		The state of the s	1	2/									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 10:05 AM Geraldine Lucille Lannen April 20,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Genesis Heritage Meridian Ctr. Dundalk If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🙀 F Director 85 July 6,1922 Ohio <u> 293-18-3414</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be maithed at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with 21222 United States 7801 Peninsula Expy Apt. 107 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2No Specify: White Specify: <u>چ</u> 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within I tealth and Mental Hygiene. m 27 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Hancock Gerald Cox Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trauonce. 20199 Saxis Road P.O. Box 35 Saxis Virginia 23427 Deborah A. Hohman (Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of H 20a Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-23-2008 Baltimore Maryland Moreland Cemetery 22. Name and Address of Facility Duda- Ruck Funeral Home of Dundal 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine PULMONARY DISEASE The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) nding physician are as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? after 3 Ectopic pregnancy Por Day Year 5 Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 □Yes 2 1 □Yes 2 NO **Director:** After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Unursing Home 5 | Residence 6 | Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: al or Attending F Division 1 Natural 5 ☐ Pending investigation 2 🗆 No 1 ☐ Yes 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie Date filed (Month, Day, State Registrar

08-02982 Donald L. Murphy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

			1- For State	or waryland	Certificate		i		eg. No.				
,	Physici al Exami	an/	1, Decedent's Name (First, Middle, La Donald L. Murphy	st)				2. Date of Dea Month April 16, 2	Day Year	3. Time of Death 1616 hrs			
			4a. Facility Name (if not institution, gi 608 Meyers Drive	ve street and number)		4b. City, To	own, or Location of Sville	Death	4c. County of D Baltimore (
	Funeral Director		5. Social Security Number 6. \$ 215-30-0478 1	F 7. Age	(In yrs. last birthday)	If Under Months		Min		b. Birthplace (State or oreign Country) MD			
	w any		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 Yes 2 X No			
	Maryland 28a-f show d at once	Director	MD Baltimo	re	Catonsvil	LLE 10f. Zip (Code		10g. Citizen of What				
	the Ma 3a or 28		608 Meyers Drive			2122	8		U.S.A.				
	death with or items 2: must be n	Funeral	11. Marital Status 1 X Never Married 2 Marrie	1 Yes 2	ver in U.S. 13.	If Yes, specify	Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	0- 14. Race - A White, e				
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	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, th. Medica	ပ၂	17. Father's Name (First, Middle, Las	•				Name (First, Middle,	Maiden Surname)				
	212 ould be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co										
	MD 2 sho afth and m 27 is aumati		William Murphy/	Brother	96 S	hannon	Drive N	ewport New	7s, VA 236				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specia	Removal from State	Meadwor	r other place) Ldge_Me Par	morial k	4-21-2008	Elkridge	, Maryland			
	Balt permit. Departs Import injury		21. Signature of Funeral Service Lice	ASSECT VICTORIAN CONTRACTORIAN	7	2. Name and A	Address of Facility	Ambrose Fu ring Rd. A	neral Hom rbutus MD	e, Inc. 21227			
	Physician		23a. Part I. Enter the disease, or confailure. List only one cause on							Approximate Interval Between Onset and			
-	Medical ≟xaminer	n s	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic C		Disease				Death			
		<u>.</u>	Sequentially list conditions,	Due to (or as a consec	guance of:								
	,	miner	(Disease or injury that initiated	Due to (or as a consecutive to conse		••							
	vecuted 1 and - transit	E Xa	events resulting in death) Last	d	quence or).								
	ial	Medical	UNPENDED	AMENDED									
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2	Fetal death	3 Ectopic	pregnancy	23d. Date of de Month	elivery Day Year			
	that the death certification by the attending detached for use as t	Physician/	1 Yes 2 No 9 Unknow	vn 9 Unknown	ime or death 5	Other (Spec	cify)						
	P.O. res that the signed by t	<u>ک</u>	Part II. Other significant condition	contributing to death	but not resulting in t	he underlying	cause given in Pa			ute to the cause of death? Probably 4 ✔ Unknown			
	cords, P.C. law requires that has been signed to 2 should be deta	Completed							opsy prie formed? dea	ere autopsy findings available or to completion of cause of ath?			
	ing Physician: The law After this certificate has funeral director, page 2 s		25. Was case referred to medical				26.Place of Death	1 ✓ Yes	2 No 1	Yes 2 No			
	Vita ystcian this cer directo	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpa		OA Other	Nursing Home 5	Residence 6	Other: Scene			
	Division of Vital Records, tal or Attending Physician: The law requirer after death. al Director: After this certificate has been sited in by the funeral director, page 2 should t	۱	27. Manner of Death 1 Natural 5 Pending		ry 28b. Time ear)	of Injury 2	28c. Injury at Work		e how injury occurred				
	Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certification of the Hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Certification:	2 Accident Investigate 3 Suicide 6 Could not determine	ot be 28e. Place of Inju	ury - At home, farm,	street, factory,	, office building, et	c. 28f. Location or Town,		or Rural Route Number, City			
	o the Hosy ithin 24 ho o the Fun	Medical C	29a. Certifier 1 Certifying Phys one) 2 Medical Examin	ician: To the best of my er:On the basis of exam and manner stated.	knowledge, death on hination and/or inves	ccurred at the tigation, in my	time, date and pla opinion, death oc	ace, and due to the car curred at the time, dat	use(s) and manner a e and place, and due	s stated. e to the cause(s)			
	F % F 8	Me	29b. Signature and title of certifier			. 290	o.C.M.E.		29d. Date signed April 17, 200	(Month, Day, Year)			
	, ħ		30. Name and address of person wh	o completed cause of de	eath (Item 23a)		J. J. J. J. J. J. J. J. J. J. J. J. J. J						
	10			ant Medical Exam		n Street, E	Baltimore, MD	21201					
	S Regis	tate	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	ask s							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM'S perFH 6879.5/2/08 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:45A M Wyndham Barry Moore 4-18-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2164 Vailthorn Rd. Middle River Balto.Co. 7. Age (In yrs. last birthday, 57 yrs. If Under 1 Year if Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (4) Date 1 95 (ear) Birthplace (State or Foreign Country) **Funeral** Hours 1 1 M M 2 □ F Director 216-54-1492 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2√ ☐ No Md. Balto. Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2164 Vailthorn Rd. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) <u>4yrs</u> Recreation Director Balto. Co. Parks & Rec. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wyndham K. Moore ပ Gladys Knotts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr once. Kevin Moore Brother 21220 2164 Vailthorn Rd. Middle River, Md. 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills 4-22-2008 Balto.Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 6 Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (LAR disease or condition resulting in death) TAS/11/10 /Medical Due to (or as a consequence of): Examiner VEIN 57/C MONTHS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown ģ signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate l 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\sum \)Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 HUERB PhilaDR 11chAF

State

Registrar

31. Date filed (Month, Day, Year)

2 4 2008

32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Fegistrar's Signatur

2008

		•	1- For State of Maryland / Department of Health as Certificate of Death		giene () ()	8 13412
			Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
п	Physicia	an	James Mac Mevamie	APRIL		Year 8:00 AM
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of		4c. County o	
1	Examin	er	MISTY RIDGE ASSISTED LIVING SYKESUILL		-	RROLL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birt		Birthplace (State or Foreign Country)
	Funeral Director		089 14 6331 11 M 20 F 85 Yrs. Months Days Hours	Min. (Month, Day	1 1922	NEW YORK
			Usual Residence of Decedent	1,7 == 1		
	ylan		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	h the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	hat Country?
	th wil	aic	110 TERRAPIN DRIVE 21784		U	SA
	72 hours after death with the Maryland natural', or items 23a or 28a-f show jical Examinal must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original Mexican	in? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, , White, etc.
9	after or it		1 Never Married 2 Married 1 Yes 2 No 1942 1 Yes 2 No Specify:	,,	Specify:	4
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altimore,	permit. Pag Department Important: I any injury o		. 4 □ Donation 5 □ Other (Specify) South CAMON Chem . T 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Ba	permit. Depart Import any inj		1 1 0 M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
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	nsit	Examin	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Wap T	1500	80.
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٦,	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
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J Of	ding Phi After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe I	now injury occorre	od P
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Division	r Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox		er or Rural Route Number,
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	day 4 hou Fune ely fil	edical	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	one) and manner stated 29b. Signature and title of certifier 29c (License number		29d Date/sinned	(Month, Pay, Year)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 3. Time of Deam 2008 **Physician** PHIL /Medical 4a. Facility Name (If not institution, give street and num. 4c. County of Death **Examiner** NA INAT KOSPITAL OF BA 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be Pimlico Rd Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) wast remain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MINCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Olstory MJ 21133 Department of Health a Important: if item 27 is any injury or other tra Mince Daiobe Brenda Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Raltimue, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Greene Junealsuc Ci andallstain, MD 21133 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as circliac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): SEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner PIRATORY Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CARDOMYOPATHY 3 ☐ Probably 4 ☑ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Division or Vital the Hospital or Attending Physician; hin 24 hours after death. the Funeral Director; After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1. Uertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 30. Name and address

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year DOREEN MIRVIS 22 7:45P APRIL 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 🛣 F 369-28-9355 76 11/14/1931 ΜI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 No MD N/A BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 2902 TERRY DRIVE 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHITE 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY STATE OF CALIFORNIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WOLF LOUIS SYLVIA UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL SPIEGLER / DAUGHTER 6228 BENHURST ROAD, BALTIMORE, MD 21209 Place of Disposition (Name of cemetery, crematory or other p. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State MAALEÍ GILBOA CEM. ISRAEL 04/23/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Livins e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER 6 MONTHS Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 🕻 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

Examiner be exect Box 68760, attending physician as the for Division or Vital Records, P.O.

or Attending

Physician

/Medical

certificate After this funeral To the Hospital or Attendir within 24 hours after death.

To the Funeral Director A completely filled it by the fu

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed

Be

2

Certification:

Medical

2 Accident

3 Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation 6 Could not be determined

eaus :

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0053928

28f. Location (Street and Number or Rural Route Number, City or Town, State) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

04/22/2008

30. Name and address of peren who completed cause of death (Item 23a) (Type, Print) SURAIYA BEGUM, MD 2434 W. BELVEDERE AVENUE, BALTIMORE, MD 21215

MD

and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

APR 24 2008

327 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fb 9878 4-24-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Margaret Amelia Parks-Witt April 16, 2008 10:12 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane Apt. 336 Catonsville Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🔽 F 90 219-34-6684 Director 1917 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified of once. 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Director MdBaltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane Apt. 336 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teller Bank 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard A. Frohlinger ٩ Elizabeth Walthouser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Schroeder/Son 1312 Monkton Rd. Monkton, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place)

UN Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-25-2008 Wye Mills, Maryland 4 Donation 5 ☐ Other (Specify) And Address of Facility
And Prose Funeral Home, Inc.
(1328 Sulphur Spring Rd. Arbutus MD 21227 21. Sig atu e Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death emention Immediate Cause (Final hysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit and A Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes 2 **1**0 funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No မှ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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Maide

egistrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12:05 A^M Emily 21, 2008 Petitt Μ. April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HCR, Manor Care - Ruxton Towson
1 Year | If Under 24 Hrs. Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖫 F Yrs. Oct 23, 1915 | Maryland Director 92 214-20-2870 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes XXNo Director Maryland | Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 405 Plumbridge Court, #301 21093 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 06 n/a <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othu any Injury or other traumatic event, once. Be Eugene မှ Jeanneret Emily Sebena Morlock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Plumbridge Court, #301, Timonium, MD of Disposition (Name of Date 20c. Location - City or Town Doris M. Stambaugh/Friend 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/23/08 Metro Crematory Catonsville, Maryland 21 2000 (10) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 Bryan W. Clary 23a. Par . Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immedi te Cause (/ inal disease r conditi n resulting in leath) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of Figure that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit K^E Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📈 No for Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform 1 Yes 2 2**XX**Vo Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore,

filled in

Medical

State Registrar

DHMH 17 Rev 1/2001

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and

6 ☐ Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer stated.

29c, License number

1757722

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 23, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18,2008 **Physician** Month PARKER, SR. LOUIS W. APRIL 11:44p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Days Months Min. 1**X**M 2□ F 86 JULY 8,1921 216-12-7863 MARYLAND **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 607 ADMIRAL DRIVE #203 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes, 2 No If Yes, Give Year or Dates 1944-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 2XNo þ Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ANALYST WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN J. PARKER 2 JENNIE BALLING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISABEL PARKER/ WIFE 607 ADMIRAL DRIVE # 203, ANNAPOLIS, MD., 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. 4/23/08 TIMONIUM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD. 21224 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician pheumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Obstructive Pulmon any Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in list and on the cause). Examiner Dire to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burish-transit mipletely filled in by the funeral director, page 2 should be detached for use as the burish-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □Yes 2 □No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical 29a, Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and Me of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of AMC 2001 MEDICAL PKWY., ANNAPOLIS, MD 21401 Stepk
31. Date filed (Month, Day, 1220 Begistrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

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Division

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 04 20 2008 Regina Mary Popp 08:15a [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/07/1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🕱 F MaryTand 79 Yrs. 219-22-8591 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be northed at 1 ☐ Yes 2 No Directo Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 1345 Dalton Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛛 No Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Heath and Mental Hygien Important: If Item 27 Is marked other th. any Injury or other traumatic avent Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Anna Koubek William Adam Schmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Larch Court, Edgewood, MD 21040 Barbara Hasselbarth, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 04/23/2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Blain Tovara, W 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause () leads or in july that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physiclan and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1 □Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1∐ Yes 2 😿 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course o 29a. Certifier Medical Wor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 2300 DULANEY VALLEY RD. ERNESTINE WRIGHT TIMONIUM, MD 21093 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 24 2008

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

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Dawn Kmieciak (Daughter) 17128 Old National Pike Frostburg MD 21532 200. Method of Disposition (Name of Controller), Journal of Security of Controller), Journal of Security of Controller, Journal of Controller, Journa		d Me d Me nark natic	卢									•					
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Due to (or as a consequence of): The control of the control of		cuted	Ē	Cause (Disease or injury that initiated events	_											 	
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The state of the s	5	ding h. Afte fune	흔	1 Natural 5 Pending		(Mon	th, Day, Yea	r) Injury					.ou. Describe i	iow injur	y occurred		
4 Homicide determined building, etc. (Specify) 29a. Certifier (Check only only only only only only only only	0	deat deat ctor: y the	ca	3 ☐ Suicide 6 ☐ Could r	not be	8e Place	of Injury . A	At home form etr			163 2		Of Logation //	Cém né na	d March D	In the same of the same	
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Check only one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Bolto Month, Day, Year) 31. Date filed (Month, Day, Year) 32 ftegistrar's Signature 31. Date filed (Month, Day, Year) 32 ftegistrar's Signature 32 ftegistrar's Signature 34 ftegistrar's Signature 35 ftegistrar's Signature 36 ftegistrar's Signature 36 ftegistrar's Signature 37 ftegistrar's Signature 38 ftegistrar's Signature 38 ftegistrar's Signature 39 ftegistrar's Signature 30 ftegistrar's Signature 31 ftegistrar's Signature 32 ftegistrar's Signature 34 ftegistrar's Signature 36 ftegistrar's Signature 36 ftegistrar's Signature 37 ftegistrar's Signature 38 ftegistrar'		pours ours eral filled		29a Certifier 1 Certifyin	a Physicia	n. To the	hest of my	knowledge deat	h occurred	at the tim	no data a	nd place .e	and due to the	221122(2)) and manner	a stated	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 22, 200 f 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 2 4 2008		24 h	<u> </u>	(Check only 2 Medical	Examiner:	On the b	asis of exar	nination and/or ir	vestigation.	in my or	pinion, dea	ath occurre	ed at the time	date and	I place and du	e to the cause(s))
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. L. (24 G. B.M. C. G. 70 (M. Charles St. Balto and Z. 20) State Registrar APR 2 4 2008 April 2 2, 200 s April 2 2,		ompl	Š	29b. Signature and title of certifier		A	1 17		29c.	License	number			29d. Dat	e signed (Mon	th, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1) A - R. (ey GBMC 670 (N. Charles St. Bolto and 2120) State Registrar APR 2 4 2008 32 Registrar's Signature				> 21 that	2-	K	I.	, com	1	25	- 20	25		An	1:12	2, 200.	f
State Registrar State Registrar APR 2 4 2008 State State Registrar	7	1	-	30. Name and address of person	who comple	eted caus	e of death	Item 23a) /Time	Print)	^				1			
State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 2 4 2008		7		W. A. Riles	16	BIN	10	670(N. a	hou	les	St.	Bal	to.	and	21201	k
Registrar APR 2 4 2008 April 19 April 1		Stat	e			32/A	egistrar's S	ignature									
		Registra	ır	APR 24	2008	SA.	ALL .	15 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month '2 Year WILLIE APRIL ROGERS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE CIT 5. Social Security Number SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days 1 M 2 □ F 239-40-6447 JANURY 17, 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 pres 2 No BAITIMORE m.D 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2.5.1. 1182 E. NorThern 21239 PARK WAY 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?
1 ☑Yes 2 ☐ No / 950 = 1952
If Yes, Give
Year or Dates: / / / / / / 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Repairing Machines Repair CARS Elementary/Secondary (0-12) College (1-4or 5+) Me Chanic 125RAde None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 4RThuR Julia Lucos ROGERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) homas 1182 E. NOrThern PKWAY BAIR.MD. 01239 -Renc1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition APRI125,200 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FORESTI. A CEN Owings Mills my 4 Donation 5 Other (Specify) 21. Insture of Funeral Service Licensee 22. Name and Address of Facility Home Betts Funcent Home 1129 N. CAROLING ST. BALTOMD 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): CARDIOVASCULAR DISEASE , ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Inju Wo

Examiner burial-tran Records, P.O. Box 68760, death certificate be the atten for u signed by the a s certificate has be lirector, page 2 s or Vital

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

other traumatic event, the Medical

ō permit. Page Department o Important: If any Injury or

Physician

/Medical

marked other

of Health and Mental fitem 27 is marked o Pages 1 and 2 should be

Funeral Director

Completed by

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Examiner

Completed by Physician/Medical

Be

Medical Certification; To

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

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26. Place of Death (C	heck only one				
ner: 4 Nursing Home	5 🗌 Residen	ce 6 🗆 O	ther (Specia	fy)	
ry at 28d rk?] Yes 2 □ No	l. Describe how	injury occi	urred		
28f	Location (Stre	et and Nun	nber or Run	al Route Number	r.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APPIL 14, 2008 MD 8

30. Name and address of person who campleted cause of death (Item 23a) (Type, Print)

BUD BALTIMORE, MD 21238 PAVEN KERITH JOSEPH 5601 M.D. 32. Registrar's Signature

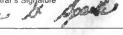
State Registrar

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31. Date filed (Month, Day, Year) APR 2 4 2008

5 Pending investigation

6 ☐ Could not be



ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2905 Dol Field N/C BAHTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 237-28-6461 MAY 181920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Nes 2 No Director M.D. BAITIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number N.S.A 21215 3905 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ひらいだり りゅうしゅう ひらいだり りゅうしゅう Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BlACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) or other traumatic event, the Medical (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than ONGShOTEMAN Dock Worker MONE GLAde 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be and 2 should be ealth and Mental GEORGE TOTICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Frint) 905 DolField Ave BATTIMORE, MD.21=
Date 20c. Location - City or Town, State Department of Health a Important: If item 27 Is any injury or other trainonce. Ro T471 MD.21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Mem. PK. APEI 23,200 2 King 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility
Betts Functory Home
1129 N. CARDINEST. BRITO. M.D. 121212 21. Signatury of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC RENAL FAILURE years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): pivision or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORDNARY BRTERY 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed EMPHYSEMA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed SEASE PERIPHERAL VASCULAR 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 28c. Injury at Work? 5 Pending investigation 1 □ Yes 2 □ No Director: , 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARA-CUSCHANSKY 2005. 331d St. #640 BALTINGRE, ND. 21218

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Lillie Mae Roberson Apri1 2008 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Health and Rehabilitation Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Days Director 240-20-6675 84 21, 1923 Sept. NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2x No Director Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8353 Williamstowne Dr. 21108 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. white Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ James Coley Josephine Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harvey Cox / Son 8353 Williamstowne Dr., Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) April 23, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 2008 Stevensville, MD 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Singleton Funeral and Cremation Cobul M01411 1 2nd Ave. SW, Glen Burnie, MD 21061 redicce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demontra Physician En Stage 48985 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ۵ 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

10

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

delived

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Physician

CHANDELWAL, HD. 313 HOCPITAL DR., GLEN BUDNIE, Md. 21061

D0039873

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Reinhart Carl 22, 2008 12:21 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's County 29875 Washington Road Mechanicsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min **X**X M 2 □ F 53 Yrs 219-58-8555 Director 7-17-1954 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Mechanicsville Maryland St. Mary's Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or USA 20659 ms 23a must b 29875 Washington Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes XX No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: white Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Network Systems Administration Bowhead Support Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Venia A. Carl A. Reinhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29875 Washington Road Mechanicsville, MD 20659 Diane Reinhart : If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Important: If any injury or once. Glen Haven Memorial Pk 4/28/2008 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Juneral Service Licep 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Betwee Onset and Dea 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HUGINMA **Physician** MAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician ar Box 68760. Physician/Medical Se IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performed? (es 2 2 No Vital 1□ Yes To the Hospital or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tes a No 2 ☐ ER/Outpatient 3□ DOA ို Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury Voiting the Fundral after the Fundral Director: Aft 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30 Name and address of person
31. Date filed (Month, Day, Year)

APR 24 2008

DHMH 17 Rev 1/2001

who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** RICH 7:53PM 04 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2|2 F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Windson 1 ☐ Yes 2 No Director 10e, Street and Number 10g. Citizen of What Country? Funeral 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12 condary (0-12) Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked of 19b. Mailing Address (Street and Number Sband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mol 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Vau iberte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) CANCER MCTASTATIC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any second cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 ☐ Matural *2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064533 - 21 - 2008 PHYSICIAN LEVINDALE - MEBREW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVENUE BALTIMORE MI) 2/2/5 m) BABATUNDE APR 2 4 2008 32. Registar's Signature

State Registrar 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Word

31. Date filed

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N Charles

32. Registrar's Signature

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21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day 1:25 AM **Physician** Russoft u 2008 /Medical 4c. County of Death 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕶 F Months Days Hours 056-16-9600 89 06/03/1918 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a filed feet in the filed of the contract for the 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2 N No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 725 MOUNT WILSON LANE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: WHITE Specify. þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ISAACSON** ISIDORE IDA TREU ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY COHEN / DAUGHTER 3 ANGUS COURT, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 04/22/2008 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) Sigurary of Funeral Service Licensee SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheros desotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for ∐Yes 2. No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

Seay, MD 31. Date filed (Month, Day, Year) APR 24 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Donothy



29c. License number

D0053337

Suite 203

29d. Date signed (Month, Day, Year)

4-19-2008

Bultmore, Md zizoa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIT **EDWIN** 20 2008 ROSEN 6:48 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 6. Sex 1 🔏 M 2 🗆 F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 212-09-9270 89 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 MARNAT ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No WWII If Yes, Give Year or Dates: ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 □ Divorced ARMY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **CHAUFFER** TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL ROSEN SADIE ROSENBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOEL ROSEN / SON 833 RAMPART WAY, UNION BRIDGE, MD 21791 20b. Place of Disposition (Name of ANSHE PUNAH or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM CONG. 04/23/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1∐ Yes 217No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 4 Other (Specify) 1 Inpatient

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar," or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

use as the burial-transit and attending physician as been signed by the atte 2 Should be detached for as

Physician/Medical

þ

Be Completed

Certification: To

Medical

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

After this

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 | Yes 2 | 1√0 27. Manner of Death

6 Could not be determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3□ DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

Maturai

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

han lisuelli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 ASNEEM FILL COLO

SUITE

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 4 2008

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 04-18-2008 0421 A Nicholas A. Silverio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesaepake Hosptial Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□F 05-08-1930 77 Pennsylvania 190-22-8824 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10h County 1 ☐ Yes 2 No Items 23a or 28a-f sharer must be notified Directo Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 2503 Lincrest Rd Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married l Tyes 2 □ No f Yes, Give 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Defense Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony C. Silverio Carmela H. Lombardi is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Joppa, MD 21085 Michaelene Silverio (Wife) 2503 Lincrest Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gar. 04-22-2008 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service bicenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Nicholas Anthony Macolacs or Vital Records, P.O. Box 68760, The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Lateral 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 KER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral cirector: 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) e of certiffe

Registrar DHMH 17 Rev 1/2001

State

29b. Signature a

Fermin Barrie

APR 2 4 2008

31. Date filed (Month, Day, Year)

pper Chesapoake Dr. Bel Air, MD 21014

of person who completed cau death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 April **Physician** 23, Roy Seibert 4:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1505 Nicolay Way Baltimore Essex 8. Date of Birth (Month, Day, Year) 07/01/1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Days **ty** 2□ F Months Hours Maryland 213-52-4126 59 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXXNo Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1505 Nicolay Way 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1XX Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates þ Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Balto. City Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o Christian Lawrence Seibert Marie A. Lehner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Seibert (Brother) 750 Compass Road, Baltimore, Maryland 21220 nt of Health : If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2XX remation 3 ☐ Removal from State permit, Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Crematory 4/24/2008 Baltimore, Bayview 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Puneral Service Licensee 1407 Old Fastern Avenue, Fssex, Maryland 21221 23a. Part 1. Criter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebro vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Merosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Diabetes Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □ Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours To the Funeral Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the decrease of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and tifle of certifier 29d. Date signed (Month, Day, Year) D0062194 08 lm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Chintan Desai, M.D., 301 St. Paul Place, Baltimore, Md. 21201, POB STE.706 32. gistrar's Signature 31. Date filed (Month, Day, Year) State 2 4 2008 Registrar

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^D2008 April 22, **Physician** MARY VIRGINIA SERINIS 9:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** None Genesis Long Green Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day Year | October 24, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□ M 2**X**X Months Maryland 83 213-20-1831 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c, City, Town or Location 10a. State 10h County 10d. Inside City Limits ns 23a or 28a-f shov must be notifled at ¹XXYes 2□No Completed by Funeral Director Maryland | None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 1028 Upnor Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unit Clerk Hospital other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Edward Monmonier Mary Thelma Benson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 Upnor Road Baltimore, Maryland 21212 19a. Informant's Name/Relationship (Type. Print) Stephen Philip Serinis Hus 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. St Mary's Cemetery Apr. 25,2008 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Fune Inc. gnature of Funger 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC YEARS CARDIOVASCULAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and burial-trar Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **2** No

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Be

Medical Certification: To

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

or Attending Physician: The law requires that the death certificate be executed

this

within 24 hours a

Division or Vital Records, P.O, Box 68760;

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of 28d. Describe how injury occurred

031/36

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9005 KILBRIDE RD, BALTIMORE, 32. Regis 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Frederick J. Smith April 22, 2008 50 C M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ManorCare Woodbridge Valley N.H. Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ★M 2 ☐ F Director 56 213-60-7242 Oct. 10, 1951 Usual Residence of Decedent filed within 72 hours after death with the Maryland sa or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director MD Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ss 1 and 2 should be filled within 72 hours after death w of Health and Mental Hygiene.

3a arranged and a starked other than "natural", or items 23a rother traumatic event, the Medical Examiner must be 133 Embelton Road 21117 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Home Improvement 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick B. Smith ဥ Josephine Krason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and ment of Health and John Knopp Cousin 915 Grove Hill Road, Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/25/08 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician NEURUENDOCKINE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE REISTERSTOWN MD BUSINESS 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar amend #23a Per PHY G884 10/24/08 THE Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year JAMES W. THOMPSON SR. 2008 April 21 12:00 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS-DULANEY VALLEY TOWSON Timonium BALTIMORE CO 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1**X** M 2 □ F Director 212-22-0564 81 14 1926 Aug MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Modical Examiner must be notified at Directo 1XXYes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a 1020 E. 33Rd St. Funeral Apt 113 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. 1 Never Married 2 Married 1XXes 2 □ No Maryland 21215-0036 If Yes, Give Year or Dates: 45/47 1 ☐ Yes 2X No ģ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12yrs K & W FINISHERS PRINTER 2vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ ARTHUR B THOMPSON CLARA GOODE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Anna Thompson-Smith/Daughter 2213 Braddish Ave., Baltimore, Maryland 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State 4 Dongtion 5 ☐ Other (Specify) GARRISON FOREST 04-28-08 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licerate 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Melana Moun 1206 W NORTH AVENUE 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) a. PANCREATIC CANCER Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to fine distances. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to (or as a consequence of) death certificate be executed burial-transi Exami and Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 1 □Yes 2 No 1 🗆 Yes 2 □ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence SCOther (Specify) HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 2300 DULANEY VALLEY RD. ERNESTINE WRIGHT TIMONIUM, MD 21093 31. Date filed (Month 32. Reastrar's Signature State Registrar

DHMH 17 Rev 1/2001

12:00

2008

21,

THOMPSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:30A M James E. Timmers 4-21-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Residence Perry Hall Balto.Co. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min 1 X M 2 □ F 81 Months Days Hours Director 119-16-7314 7-5-1926 NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evernment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Md. Balto. Perry Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 11 Haylock Ct Apt. 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chauffeur <u>Transportation</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ George Timmers Della Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Haylock Ct. Apt. 302 Perry Hall, Md. 21236 sposition (Name of Date 20c. Location - City or Town, State Helen E. Timmers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Maus. 4-24-2008 Balto.Md. 21. Signature of Funeral Service See 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 07 /Medical But to or as a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 213 熔 this certificate has been signed by the attending physician a af director, page 2 should be detached for use as the burial-Due to (or/as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AS Cu 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Accident Natural 5 Pending investigation 1 🗆 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Medical 3

State Registrar

29a. Certifier

29b. Signature and title of certifier

and manner stated

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 2 4 2008

3. Registrar's Signature

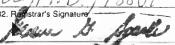
		Registrar 1. Decedent's Name (Fir	st. Middle Last)		Certificate of	Death	2. Date of Dea	teg. No.		3. Time of Death
Physiciar /Medica	n	Eleanor Pa							18 ^{Day} 200		9:20 PM M
Examine	r	la Fecility Name (If not Broadmead	institution give Health	street and numbe Care Cen	ter	4b. City, Town, o	r Location of Death Cockeysvi	.lle	4c. County Balti		
Funeral Director		5. Social Security Number 212,32.13 July Security Summer Security Number Secu	41 10	7. A	Age (lg yrs. last b	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	71912	9. Birthple MD Countr	ce (State or Foreigi y)
in a how		10a. State 10b	County Baltimor	e		wn or Location				10	d. Inside City Limits
3a or 28s	runeral Director	10e. Street and Number 13801 York	Road			10f. Zip Code 21030			10g. Citizen of V USA	Vhat Count	y?
	2	11. Marital Status 1 ☐ Never Married Midowed 4 ☐	2 Married	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ₹¶ō	13. Was Decedent of H If Yes, specify Cub		ecify Yes or No- Rican, etc.)	Blac	e - America ck, White, et :: Whit	c.
iene. r than "natur the Woolcal	Completed		Decedent's Edu nly highest grad y (0-12)			a. Decedent's Usual Dccup (Give kind of work done life. DO NOT use retire eacher	pation during most of work d)	ing	16b. Kind of Bi Private	usiness/Indu B	istry
Mental Hygiene arked other tha atic event, the Tree	o ge C	17. Father's Name (First Lindly Ell	, Middle, Last) icott Pa	rker			18. Mother's Name Anna B.		Maiden Surnan	16)	
Ilth and Mills in traumati		19a Informant's Name/I Fred Terry/	Relationship (Ty Son	pe, Print)	19	b. Mailing Address (Street 747 Bomont Ro	and Number or Run oad Luther	al Route Numberville I	r, City or Town, Limonium	State, Zip (Code) 21093
Department of Health a Important: If item 27 i any injury or other tra gnce.	-	20a. Method of Dispositi 1 ☐ Burial 2 ☑ Cre 1 ☐ Donation 5 ☐	emation 3 DF		20b. Place cemet Chesa	of Disposition (Name of ary, crematory or other plan apeake Crema	tory Inc.	Apr 22 2008	20c. Location - Beltsvi	-	
Departimonts any in gance.		21. Signature of Funeral	Service Licens	Ritte	M01442	8717 Green				, Mary	land 2128
physician and Medical transit transit transit and management and m	Cal Exa	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition of any, leading to minimulate the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(END (07)	s a consequence	of Co	PD				Onset and Death
d by the attending phyletached for use as the	ysiciativine	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	jnant		e of pregnancy 2 ☐ Fetal deat at time of death	h 3 Ectopic pregnancy 5 Other (specify)	/			e of deliven	/ Pay Year
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his certifical director.	ם כ	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No		lospital: 1 ☐ Inpa	tient 2 FR/C	utpatient 3 DOA Oth	26. Place of Deat	n <i>(Check anly ar</i> me 5 ☐ Resid		ar (Spanific)	
After the funeral	allon.	27. Manne of Death	Pending investigation	28a. Date of In (Month, D	iury 28b.	Time of 28c. Injury Wor	y at	28d. Describe h			
within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral Madical Cartification.		3 Suicide 6 (4 Homicide	Could not be determined	28e. Place of I building,	njury - At home, t atc. <i>(Specify)</i>	arm, street, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
5 6 2	9	29a. Certifier 1	Certifying Phys	sician: To the bes	of examination a	e, death occurred at the til	me, date and place,	and due to the c	ause(s) and ma	inner as sta	ted.
within 24 hours To the Funeral completely filled	מַלַ	(Check only 2 one)	Medical Examil	and manner	stated.		phillori, death occur		ato and place,		

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

BARBARA CARRO 31. Date filed (Month, Day, Year) APR 2 4 2008



08-03103 Rodger Whetzel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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J		1- For State Certificate of Death Reg. No.	7 0
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Mouth Day Year	
M 'al Exami	ner	200 GER WILLIS WHETZEL April 21, 2008 1434 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
4		Carroll Hospital Center Westminster Carroll	
Funeral		5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MW/DD/YYYY) 9. Birthplace (State or	
Director		214 68 0406 1 MM 2 F 52 Yrs. Months Days Hours Min. July 15 1955 Foreign Country) MO	
		Usual Residence of Decedent	
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te Maryland or 28a-f show any fied at once.	rec	Tot. Sireet and Number	ĺ
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	401 RAMS HORN COURT 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	
ath w	ner	1 Never Married 2 Married 2 Married Armed Forces? 1 Yes 2 No	
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: WHITE	
ours a satura xamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	10
16 n 72 h isan "n ical E	olete	Elementary/Secondary (0-12) College (1-4 or 5+) CARROLL COUNTY B	0
OO3 withingiene.	Completed	17. Father's Name (First, Middle, Last) BUILDING SUPERVISOR OF EDUCATION 18. Mother's Name (First, Middle, Maiden Surname)	\dashv
21215-0036 uld be filed within 73 Mental Hygiene. marked other than ic event, the Medical	Be C		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. I. Titlem 27 is marked other than "natural", coher traumatic event, the Medical Examiner I	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
MD d 2 sho lth and n 27 is		JAN WHETZEL / WIFE 401 RAMS HOW COURT ELDERS BURG MD 217 20a, Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	-84
s l an of Hea If iter		crematory or other place)	
or familie		4 Donation 5 Other specify: South CANOI GREMATORY 4/25/2006 WINFIELD, MO	
Baltimore, MD 21215-00; pernit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBNN FH & MON CO- 16028 SYKESVILLE ROUND FLORIS BURG MD 2178	. u
Physician		23 Part I. Enter the usy ase or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart Approximate Inte	erval
Medical		failure. List only one cause on each line. Death Death	and
<u>≁,, </u> ≟xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive attreroscrerour cardiovascular disease Due to (or as a consequence of):	
	_	Sequentially list conditions, b.	
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Classes or individual to lititates C.	
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Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
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Division of Vital Records, P.O Ital or Attending Physician: The law requires that the after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Į	3 Suicide 6 Could not be determined determined determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State)	City
Lospite f hour uners	ဦ	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only	
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F. N. S.	Me	DGME DGME	
		Theodor M. The Try und O.C.M.E. April 22, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Regi:	itate	APR 2 /1 /1010 Magazana 2 /2	

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** April 15, 2008 9:50 A M Mary D. Warnick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4230 Hollins Ferry Road. Apt. 108 Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Old Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/11/26 6. Sex Birthplace (State or Foreign Country) **Funeral** 216-80-8691 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4230 Hollins Ferry Rd. Apt. 108 21227 or iteme 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: if item 27 ie marked other than "natural", or ite 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 22 No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Complete (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Smith Minnie Hurt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4230 Hollins Ferry Rd. Apt. 108 Baltimore, Md. 21227 Mr. Maurice Warnick / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Himportant: If ite eny injury or of page. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4/21/08 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or conditions the condition is death. Approximate Interval Between Onset and Death dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. BRANST CANCER Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 HNo 3 Probably 4 Unknown Completed peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) _2 € No 20 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 al atural 5 Pending death. investigation 1 Tes 2 No within 24 hours efter death.

To the Funeral Director; completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22 D21336 son who completed cause of death (Item 23a) (Type, Print) KITCHIE HINT, Cultur II 8026 (ASAGNA, 4) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 24 Registrar

	1	For State Registrar		Sta	ite of M	larylar		artmen <i>tificat</i>				lental Hy	giene Reg. No	7 11	3 0	1343	d
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/Medica	4	Lucille										04/2	22/20			03:00 a	N
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or important: If item 27 is marked other than "natural"; or any liury or other traumatic event, the Medical Exami ang. TO Be Completed by Item		4 ☐ Donation 21. Signature of Fu				INU		. Name ar		,		eonard.				•	_
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			For State Registrar	State of I	Marylan			nt of H te of L		nd Me		giene Reg. No	2111	8	13439
J	Physic /Medi		1. Decedent's Name (First, Middle, La EDWALD	st)		Wi	レモ	۲,s	۳.		Date of De Month	ath Day	,	Year	3. Time of Death
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980	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? No		Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specit Puerto Ri	fy Yes or No- can, etc.)		14. Race	- America White, et	n Indian,
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Maryland	hould be file d Mental Hy narked oth natic event	To Be	17. Father's Name (First, Middle, Last) Edward Wiley 19a. Informant's Name/Relationship (pe. Print) 18. Mother's Name (First, Midd Mable J. Crumb 19b. Mailing Address (Street and Number or Rural Route Num							ine			
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Baltimore,	nit. Pages artment of ortant: If it injury or c		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Liceration of	y)	re l	Place of Dispondentery, cres	11 M	em. G	dns. 4	/24/	2008	Mic	ddle River, MD		r, MD
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7	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. The	line. Lulal as a conseq	R D	ropol	yel	D 1023	nce				د د	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequals as a consequ										
P.O. Box 68	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 🗌 Feta at time of d	ıl death 3 □]Ectopic ¡] Other (s	pregnancy specify)				2	3d. Date Monti	of delivery	/ Day Year
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r Vital	di is	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	itient 2	ER/Outpatien	t 3 🗆 D	OA Othe			Check only of 5 ☐ Resid			(Specify)	
Division or	ing After	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be		Day Year)	28b. Time of Injury	М				d. Describe h		_		
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 ☐ Homicide determined	building,	etc. (Specif)	y) 					City or Tow	n, State)			Route Number,
	the Hos iin 24 ho the Fun tpletely 1	Medical	29a. Certifier (Chack only one) 1 Certifying Ph 2 Medical Exam	niner: On the basis and manner	of examina	wiedge, death	vestigatio	at the tim n, in my op	e, date and p inion, death	occurred	d due to the o	cause(s) date and	and manr place, an	ner as stated due to t	ted. he cause(s)
1	To To To To To	Σ	29b. Signature and title of pertifier) stell	den	war	,	c. License	11/		L	1/- 1	120	Month, Di	
	10+1		30. Name and address of person who o	URTELL	mb.	23a) (Type,	Print)	EAST	ENN ,	quen	100 8	BAU	Time	ME,	21224 MA
3	Sta Registr		31. Date filed (Month, Day, Year) APR 2.4 20	32. Jegis	strar's Signa	ture	alle	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 21 ay 2008 RONALD NORTON WARONOFF 10:55 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month | Days | Hours | Min. | 06/18/1931 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign WASHINGTON DC 579-38-6789 76 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits HOWARD COLUMB I A 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8888 STONEBROOK LANE 21046 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IZYes 2 □ No KCREA If Yes, Give Year or Dates: FORCE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) STORE PLANNER CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WARONOFF ABRAHAM MARIAN FINK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE RUTH WARONOFF / WIFE 8888 STONEBROOK LANE, COLUMBIA, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CCCOMB FAMILE MORTAL PARK 1 Burial 2 □ Cremation 3 □ Removal from State 04/23/2008 CLARKSVILLE,MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Privion 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications to a cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in ear line. Approximate Interval Between Onset and Death Immediate Ceuse (Final METASTATIC RENAL CELL CANCER disease or condition resulting in death) YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of the trait initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' 1 ☐ Yes

Physician /Medical Examiner

AN

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 23a

7 Is marked other than "natural", or items 23s traumatic event, the Modical Examiner must

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Funeral Director

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death with the Maryland

Baltimore, Maryland 21215-0036

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Division of Vital Records,

Pages ' 5 permit. Pages
Department of
Important: If it
any injury or c

> sician and burial-trans ned by the attending physician detached for use as the burial cate has been si

Be funeral c the

Certification: To

that the death certificate be executed After this To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by

Medical State Registra

Physician/Medical <u>ک</u> Completed 25. Was case referred to medical

> 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 4 - Homicide

1 ☐ Yes 2 No

27. Manner of Death

29a. Certifier

(Check only one)

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 6 Detection (Specify) HOSPICE

28d. Describe how injury occurred

D64395

29d. Date signed (Month, Day, Year) APRIL 21, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N OHARLES ST, SWITE 209 BALTIMONE, NO 21204 DANIEUE DEBERMAN, MO 6565

31. Date filed (Month, Day, Year) APR 2 4 2008

29b. Signature and title of certifier

32 Registrar's Signature

Bouchner Baltimore, Maryland 21215-0036

amend site of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GUY BOUGHNER RONALD 1008 AM APRIL 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTO, MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Nonths Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) Funeral 1MM 2□F 316-42-2727 Director NEW SERSEY JUNE 26 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD GLEN BURNIE ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 456 OLD QUARTERFIELD ROAD 2106 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SERVICE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BOUGHNER CAROLYA BEHA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN BOUGHNER 456 OLD QUARTERFIELD ROAD, GLENBURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) MATOMY GIFTS PEGISTRY APRILOS, DOOR HANDVIED, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DOOR OM, SOUDHARD FELLEN CONTRACT DE HANDLEY DE HANDLEY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Physician/Medical the attending F FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 2 🗌 No 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2∐No 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 2□/No 1 Inpatient Division or After th funeral 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 _ Natural Jopital C.
4 hours after dec.
Theral Director: After in by the further in the formula in the for 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Vithin 24 hours and.

To the Funeral Direct

Totally filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil Chopra Baltimore Washington Medical Center 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AWRENCE BURIS APRIL 2003 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AMDALLSTOWN HOSPKTAL CENTER BAUIMERE 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 060-12-8735 Usual Residence of Decedent Director the Maryland a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director dlumbia 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21045 "natural", or Items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired)

Pastal Worker Item 27 Is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) ather's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental t of Health and King Rd. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or = 5 ona Island 21. Signatur of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC **Physician** CARCINOMA disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any body by the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy page 1∐ Yes or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title 29d. Date signed (North, Day, Year) HYSICIAN APRIL who completed cause of death (Item 23a) (Type, Print) NORTH WEST RLLI M KARISH 5401 040 C HOSPITAL 30. Name and address 5401 VERAHAL VA OLD COURT 31. Date filed (Month, Day, 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 5 2008

Chester Albert Bom		r Print in Black Inc of Maryland / Depar				libie.	
	1- For State Registrar	_	ificate of Deal			g. No. 200	8 344
Physician/	Decedent's Name (First, Middle,Last)				2. Date of Death	7	3. Time of Death
Medical Examiner	Chester A 4a. Facility Name (if not institution, give	1bert Bomb	er Jr	Town, or Location of Dea	Month April 13, 20	008 4c. County of Death	1940 hrs
	145 Clarence Avenue	Street and number)	1	erna Park	u	Anne Arundel	!
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. las		der 1 Year If Under 24H		h(MM/DD/YYYY) 9. Birth Foreign	
Director	197-46-7416	м 2 г 52	Yrs. Mont	hs Days Hours Mi	n. April	16, 1955 Poe	nmsylvania
any	Usual Residence of Decedent 10a. State 10b. County	10c City T	Town or Location				10d. Inside City Limits
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the Maryland a or 28a-f sh tiffed at once Director	10e. Street and Number			p Code	10	g. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f show notified at once. al Director	145 Clarence Avenu	ie	21	146		U.S.A.	
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5-0036 ed within 72 hours aft tygene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify onl	or Dates:	16a. Decedent's Usua	Occupation (Give kind o		16b. Kind of Business/Ir	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Complé	Chester A. Bomber	, Sr.		į.	u Janusz	,	
D 21 should ond Mee is man attic ev	19a. Informant's Name/Relationship (Ty			s (Street and Number of reen Lake Dr			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Andrew Bomber (Br 20a. Method of Disposition		lace of Disposition (Na		Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of He. Important: If ite	1 Burial 2 X Cremation 3	Removal from State Cr	ematory or other place	e)	/15/08		
altin mit. P. partme portan	4 Onation 5 Other Specify: 21. gnatur of Funeral Service Licens		opolitan (22. Name and			Alexandria neral Home	, VA
D Per Mini		frimm		azle Avenue,	Wilkes	Barre, PA	18702
Physician /Medical	23a. Part I. Enter the disease, or compli failure. List only one cause on each	h line.		of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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nine	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated C	ue to (or as a consequence of)	:				
ted nsit	events resulting in death) Last	ue to (or as a consequence of)	:				38
b. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	UNPENDED d.	AMENDED					
Box 68760, e death certificate by the attending physic ed for use as the bur hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy			23d. Date of delivery	<u> </u>
certiff certiff ending use as	past 12 months?	Live birth Pregnant at time of dea	2 Fetal death		nancy	Month D	ay Year
BO) e death the att	1 Yes 2 No 9 Unknown	9 Unknown	o other (op-				
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Ton the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the buriedical Certification: To Be Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not res	sulting in the underlyin	ig cause given in Part I.		bacco use contribute to t	
ds, equires een sig ould be					24a. Was a		opsy findings available
tal Records, cian: The law require certificate has been si ector, page 2 should b					autops	med? death?	ompletion of cause of
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f Vital Physician r this certi	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2 E	ER/Outpatient 3	DOA Other Nurs	sing Home 5	Residence 6 🗸 Other	Scene
n of ding P h. After funera	27. Manner of Death 1 Natural 5 Pending	(Month Day Year)	28b. Time of Injury FOUND:	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe h Subject shot	now injury occurred t self	
isio Atten er deatl rector by the	2 Accident Investigation	Apr 13, 2008	1935 hrs ne. farm. street, factor		28f. Location (S	Street and Number or Ru	ral Route Number City
Division or Strending Jours after death. Interest Director: After filled in by the fune Certification:	3 Suicide 6 Could not b determined	(Specify) Single Fami		3 ,	or Town, St		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Forneral Director: After this certificate I completely filled in by the funeral director, page ledical Certification: To Be Com	1	n: To the best of my knowledge					
To the He within 24 To the Fu Completel	2	On the basis of examination and manner stated.		ec. License number	at the time, date a	29d. Date signed (Mor	
	Janke y	el un	25	O.C.M.E.		April 14, 2008	iai, Day, rearj
	30. Name and address of person who co	()	23a)				
8	T	ssistant Medical Examin		Street, Baltimore, N	/ID 21201		
State Registrar	31. Date filed (Month APR 2 5 2	008 32. Redistrar's Signatur	& Coost				

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

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APR 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 23 **Physician** Mary R. **Brooks** Apri 2008 03:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 189 10th Street Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 01 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F 218-09-1666 89 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 'natural', or items 23a 3506 Emory Church Road 21154 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 12 Dry Cleaners is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a William Rothame1 Marv Janonis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Nancy Harris (daughter) 10th Street, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö injury Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ereprova /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical ass attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **N**0 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a Was an has certificate 10 Hospital or Attending Physician: 24 hours after death, e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: ဥ 1 🗌 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Naturai 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. To the within 2 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year) 0

State Registrar em 23a) (Type, Print)

32 Registrar's Signatr

			1 - State amend #17 per FI	ate of Marylands G879 5/0	and / Depa 1/08 ஆ	artment of He rtificate of D	ealth and M <i>eath</i>	_	giene Reg. No.2 () () {	3 3446
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	/Medi	cal		ucille	В	Bailey		4	22 2008	3 10:35p ^M
	Examir	er	4a. Facility Name (If not institution, give street Gilchrist Center	and number)		4b. City, Town, or L	ocation of Death		4c. County of De	eath
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)		If Under 24 Hrs.	8. Date of Birt (Month, Da	Balto 9.E	Birthplace (State or Foreign
	Director		248-58-5691 ^{1□M 2}	X^{F} 7	2 Yrs.	Months Days	Hours Min.	5-27	7-1935	S.C.
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho lied a	to	MD N/A		altimo					X X es 2 □ No
	r 28a	irec	10e. Street and Number	В	altimo.	10f. Zip Code			10g. Citizen of What	Country?
	th wit	ralD	1408 Montpelier	Street		21218	8		USA	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exerciting must be positive at	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever ir med Forces? ⊒Yes 2∕2 No ∕es, Give ar or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2[X]No	panic Origin? (Spe , Mexican, Puerto <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify: P	
5-0	72 ho	etec	15. Decedent's Education (Specify only highest grade com	oleted)	(Give	dent's Usual Occupati kind of work done du	ion ring most of worki	na	16b. Kind of Busines	ss/Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	life.	DO NOT use retired)		.9	Hecht C	ompany
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lary	2 shou and h Is ma auma		19a. Informant's Name/Relationship (Type. Pr	int)	19b. Mailir				er, City or Town, State	e, Zip Code) 21202
6, ₹	and tealth		Lillian Bailey-Da						202 Bal	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es once.		20a. Method of Disposition	al from State	 Place of Dispo cemetery, cren 	sition (Name of natory or other place)	i i	ate	20c. Location - City	
Itin	artme artme ortant injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Ga	arrisor	Forest	4-29-	-2008	Owings M	ills, MD
Ba	Depa Impo any Ir		har the K.	(me)		2. Name and Address			H East e Balto,	MD 21202
	Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.			such as cardiac o			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		7/7/001				gers
	Examiner		Sequentially list conditions. b							U
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwring Cause (Disease or injury	Due to (or as a cons	sequence of):					
	ficate be executed physician and s the burial-transit	xan	triat initiated events	Due to (or as a cons	equence of):	···				+
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.O. Box	to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnent in the past 12 months?	es, outcome of pre Live birth 2 F Pregnant at time of Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
Records, P.	w requires that the de s been signed by the a should be detached f	<u>\$</u>	Part II. Other significant conditions contributi	ng to death but not r	esulting in the ur	nderlying cause given	in Part I.		,	to the cause of death? Probably 4 Unknown
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<u>~</u>	Physician: The Is r this certificate ha ral director, page 2	Con						perfor	med2 death	es 2 No
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ō	Phys er this eral dii	۲	1 162 5 140	1 ☐ Inpatient 2 Date of Injury	☐ ER/Outpatien 28b. Time of		4 Li Nursing Hon		ence 6 Other (Si	pecify) to Spia
<u>o</u>	nding Ph ath. r: After th e funeral	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)) Injury	Work?	s 2 No	.ou. Dooonbo II	ow injury occurred	,
Division of Vital	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification: To	3 Suicide 6 Could not be determined 28e	Place of Injury - At building, etc. (Spe	t home, farm, streecify)	eet, factory, office	2	8f. Location (S City or Tow	treet and Number or and State)	Rural Route Number,
:	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: O ar	To the best of my ken the basis of exam d manner stated.	nowledge, death ination and/or inv	occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	and due to the o ed at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
Ì	Vith Com		29b. Signature and title of certifier	1.0	10-0	29c. License n	number	2	29d. Date signed (Mo.	nth, Day, Year)
•	4	-		d cause of death (II	tem 23a) (Type, I	Print) 1/ //	1.0	C. A.	20 Of MA	23, 2008 1 21 20x
	Stat		31. Date filed (Month, Day, Year)	32 Registrar's Sig	6/0/	M. CE	unco.	11: 1/2	ext o To	y zi cen-
	Registra		APR 2 5 2008	Robert .	H Soa	de la				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 13447 State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Florence Almeda Bowers April 20, 2008 5:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2502 Taylor Ave. Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 XF Yrs. Director Virginia 413-09-1490 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 Taylor Avenue 21234 USA Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 2 should be filed within 72 hours after in and Mental Hygiene. is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16a. Do NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 Painter Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cordelia Delephine Hayton George Washington Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other treu 9145 Lennings Lane, Baltimore, Maryland 21237 Dorothy C. McNew / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 4-23-08 Bel Air, Maryland 21. Signatur u al Service Licensie ^{22. Name and Address of Facility} McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a confequence of): Physician YEGY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sicien and burial-transit Examin Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed Accident brovascular 24b. Were autopsy findings available prior to completion of cause of death? rector, page 2 st 24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 2 🗆 No 1 Yes : After this certifice funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the eaute(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) å 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Chen lexander

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 5 2008

32 Registrar's Signature

El Aven

Box 68760,

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. Amend Items 12 per Maryland / Department of Leath and Mental Hygiene

Certificate of Death

Reg. No. 2. Date of Death 04/07/2008 1. Decedent's Name (First, Middle, Last) Ulysses Cofield **Physician** Dav Year 7:20 PM /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore lace 7. Age (In yrs. last birthday) Yrs. Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□ F Usual Residence of Decedent Director 0# 10b. County 10c. City, Town or Location 10d. Inside City Limits show at r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Ba 1 Yes 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? taw by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 (A Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) river dth permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event; 18. Mother's Name (First, Middle, Informant's Name/Relationship 19b. Mailing Address (Street and ıral Route Numbe M:11s, ODD 21117 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of uneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Cardon US Cullor Accident Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician menulii to holes /Medical Examiner Lebelation Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical MA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No H A 24a. Was an certificate has autopsy performed Division or Vital 1∐ Yes After this certification funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 10 ဥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural n 24 hours aren the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number DO041514 eman MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. N. GREEN ST Boltimae MD 21201 ALNOOR G. HEMANI, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 4 2008

Pelus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM / 8, per HI G8/8, 4/28/08 WS
State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month Harry M. Cook April 21, 2008 12:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 1920 Birthplace (State or Foreign Country) **Funeral** 11X1M 2□ F 214-12-1135 - 87 Yrs. Director Oct.13, 1929 | Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other then "neturel", or items 23a or 28a-t ehow eny injury or other traumatic event, the Medical Evaruhant must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 16 Dunmore Road 21228 USA Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 기 됐Yes 2□No If Yes, Give Year or Dates: 1942-54 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Programer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Norman Cook Agnus Delores French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Cook 713 Maiden Choice Lane, 1204; Catonsville, MD 21228 WIfe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 4/28/2008 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) allynoma **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to min additionable. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence off physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ঠ Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by wice elosenous 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 1□Yes 2₽No Other: ٩ 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; **≯** □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 68760 ed by the a detached for been signed by should be detac s certificate has b lirector, page 2 s Hospital or Attending Physician: filled in by the funeral director, s after deeth. within 24 hours a To the Funeral I the 2

Baltimore, Maryland 21215-0036

State Registrar

Medicai

31. Date filed (Month, Day, Year) APR 2 5 2008

Vary

29b. Signature and title of certified

29a. Certifier

(Check only



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

avere Care

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month April 23, 2008 Dennis Colin Chadwick 7:45 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2590 Running Wolf Trail Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 290-42-4846 57 Sept 7, 1950 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Directo 1 ☐ Yes 2 No Maryland Anne Arundel Odenton 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. Funeral 2590 Running Wolf Trail 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates:1969-72 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No ⋛ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Civil Servant U.S. Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental H ဂ္ George Chadwick Edith Μ. Braham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 shat of Health and if item 27 is n Nancy Chadwick/wife 2590 Running Wolf Trail Odenton, Maryland 21113 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ites
any injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 4/25/2008 Odenton, Maryland 21. Sign tus of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Homas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 21 months disease or condition resulting in death) Colon Cancer Metastatic to Liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2**X**) No 2 ER/Outpatient 3 □ D0A this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

2

XI

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Mayer Gorbaty, M.D.

APR 2 5 2008

DHMH 17 Rev 1/2001

and manner stated.

203 Hospital Drive

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D27938

Glen Burnie, Maryland 21061

29d. Date signed (Month, Day, Year)

April 24, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Ida Laura Covey P^{M} 2008 April 21, /Medical 2:30 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Assisted Living Mt. Airy Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Ye June 10, 6. Sax 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year) 1919 1 M 2 XF Country) Virginia Director Yrs 219-58-3004 88 Usual Residence of Decedent with the Maryland 10a. State 10b. County 28a-1 show 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Mudical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 Items 23a death v 13704 Old Annapolis Road Funeral 21771 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of the following the file of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Item ury or other traumatic event, it a Mustical Evantinal Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 □ Divorced Specify: Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Domestic Engineer One Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Isaac Floyd Rhoton Laura Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura C. Thomas/daughter 4411 Sykesville Road Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or otice. Lakeview Memorial Park 4/24/2008 4 Donation 5 Other (Specify) Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. manita K thomas 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him adiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year has been signed by the age 2 should be deteched in 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 21 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Assisted Other: 4 Nursing Home 5 Residence 6 XOther (Specify) ဥ 1 ☐ Yes 2 X No After the Living 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the 29b. Signature and title of Sertifier 29c. License number 29d. Date signed (Month, Day, Year) D0058137 April 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Stoner Avenue Suite 307 Westminster, Maryland 21157 Wilbur Y. Kuo, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 5 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per the err 879 5-2-08 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day /Medical CHARLES J. CLIFTON, JR. 2008 2:08P apr. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ☐ F Months Days 218 36 5031 67 July 16,1940 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Director BALTIMORE 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4815 LAUREL AVE. 21215 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married Married 1 □Yes 2√□No If Yes, Give Year or Dates: þ 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify:BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH FORKLIFT OPERATOR LEADER SOCIALSECURITY ADM. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) CHARLES J. CLIFTON MARTHA BROWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS M. CLIFTON (wife) 4815 LAUREL AVE. BALTO, MD. 21215 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Sec. 2) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State WOODLAWN CEMETERY Apr. 26, 2008 BALTO. CO, MD nature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 F. PRESTON ST. BALTO, MD. 21213 23a. Part 1. Enter the disease, or complications that caused the lenth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel (mcen disease or condition resulting in death) Ras Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnency Month Day 4 ☐ Pregnant at time of death Year 5 Other (specify) □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 🗹 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Funeral

Director

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or items 23a

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Baltimore,

22, 2008 at 2:08pm

State Registrar

DHMH 17 Rev 1/2001

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A. R 31. Date filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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	Registr	_	31. Date filed (Month, Day, Year) APR 2 5 20	08 planting	15 1000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 2008 **Physician** Month I RMA CHALMERS APRIL 9:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3008 LIGHTFOOT DRIVE PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 70 Director 219-34-1813 07/13/1937 MD Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner πust be notified at Director 1 ☐ Yes 2 XNo MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 LIGHTFOOT DRIVE 21208 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No WHITE Specify. Specify: ģ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** INTERIOR DESIGN 3 2 should be filed whand Mental Hygier 7 Is marked other the traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev JACK C SAHM ROSE ဥ SUNSHINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN YOUNGBERG / DAUGHTER 5 AIRWAY CIRCLE, APT. 4-B, TOWSON, 20b. Place of Disposition (Name of cemetry) graphatery of other place)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 04/24/2008 REISTERSTOWN, MD Signature of Funeral Service Lig SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arcin owa /Medical Due to (or as a c sequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) o the 9 Unknown 9 ☐ Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1□ Yes Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

| Director: ...
d in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospius C. within 24 hours after To the Funeral Dir the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2401 W Balvedere Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FELDMAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jerome	Sebastian	Carter	

			1- For State Certificate of Death Reg. No. 2	1345
Medi	Physici cal Exam	G. 1.	7 C 1 Vons	ne of Death
(4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	711113
			3903 Mewswood Lane T2 Nottingham Baltimore County	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MW/DD/YYYY) 9. Birthplace Foreign 1a T	y Land
			219-90-3895 1 x M 2 F 44 Yrs. Sept15,1963 Country)	8101636
	w any			nside City Limits
β	ryland a-f sho f once	ctor	Md. Baltimore Beachwood Estates 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 X No
7	illiOTe, MID 4 14 19-0030 Pages 1 and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.			
/	th with tems 23 at be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind White, etc.	tian, Black,
	ter dea ", or it er mus	/ Fur		-e
	iours af iatural xamin	d by	15 Daylor File (Carlotte)	
90	JO in 72 h han "n dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Technician Communicati	ona
Š	other t	Com	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	OHS
124	d be fillental Herked	Be	Walter Lee Carter Regina Cituk	
ָב <u></u>	27 is m matic	5	19a. Informant's Name/Relationship (Type, Print) FIOL DET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Jeffrey A. Carter, Sr. 4734 Greencove Circle Baltimore, Md	ode) 21219
-	T and Health		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	
	Pages ment of tant: I		St. Stanislaus Cem 4-24-2008 Baltimore, M	Maryland
100	Deficiency (NID Z 12.15-00.50) permit Pages 1 and 2 should be filled within 72 hours after dea Department of Health and Mental High edition (I filem 27 is marked other than "natural", or it injury or other traumatic event, the Medical Examiner mus		21. Signature of Funeral Service Licensee 22. Name and Address of Facility aczorowski Funeral H 1201 Dundalk Ave. Baltimore, Md. 2	lome, PA
F	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr	roximate Interval ween Onset and
	/Medical xaminer		Immediate Cause (Final disease a Cocaine intoxication	Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
		iner		
	ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
	cate be executed physician and the burial - transit	Medical		
760	physic the bur			
89 20	death certifice attending for use as t	/sician/	23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify)	Year
ä	he deatl	Physi	5 SINIOMI	
Olivision of Vital Records D	ires that the designed by the	<u>آھ</u>	1 Yes 2 No 3 Probably 4	
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Ç	he law ate has	dmo	autopsy prior to completi performed? 1 ✓ Yes 2 No 1 ✓ Yes	ion of cause of
<u> </u>	cian: The certificate ector, page	Be	25. Was case referred to medical 26. Place of Death (Check only one)	
, ,	ding hysic I. Afte this funeral dire	၉	1 Ves 2 No Impatient 2 ER/Outpatient 3 DOA Sub-4 Nursing Home 5 Residence 6 V Other. Scene	9
5	ending ath. or: Aft	Certification:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
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	Hospital 24 hours Funeral tely fillec			y Ha11 MD
	To the Hospital or Attending "hysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funer il director, page 2 should be detached for use as the burial - transi	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause	e(s)
	F ≥ £ 8	Me		y, Year)
	~		Wayvie me Shull O.C.M.E. April 20, 2008	
	8		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
_	Regist	veir_	APR 2 5 2008 Theres It Species	

08-03144 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

es H. Dyas		State of Maryland / Depart			2008	3 3 5
Dhygioi		Registrar 1. Decedent's Name (First, Middle,Last)	ficate of Death	Reg. No Date of Death		3. Time of Death
Physicia cal Exami	411/ 			Month Day April 23, 2008	Year	0913 hrs
		Charles Herbert Dyas 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
		Laurel Regional Hospital	Laurel		Prince George's	3
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	**	8. Date of Birth(MM	VDD/YYYY) 9. Birth Foreign	
Director		214-72-5294 1XM 20F 47	Yrs. Months Days Hours Min.	April 1	2,1961cour	ntry) Marylan
		Usual Residence of Decedent				
w any			own or Location			10d. Inside City Limits
daryland 28a-f show 1 at once.	ō	2	stead			1 Yes 2 X No
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number	10f. Zip Code 21074	I -	tizen of What Counti	ry?
th the		4715 Millers Station Rd.				
tems st be	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Riemann,		14. Race - America White, etc.	an Indian, Black,
er de		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Wh:	ite
ırs afi tural' imine	i by	Lor Dates:	6a. Decedent's Usual Occupation (Give kind of wor	rk done 16b.	Kind of Business/Inc	
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rthin re.	du	12	Service Manager	A	utomoti	ve
Hygie other	S	17. Father's Name (First, Middle, Last)	18.Mother's Name (F			
ental] arked	Be	Thomas Walter Dyas	Louise H			
nd Mais mis mis mis mis mis mis mis mis mis m	ြ		19b. Mailing Address (Street and Number or Rur			
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ment tant: or of			: Familv Burial Plot	:	Hamneto	ad. MD.
Depart m por m jury	ij	21. Signature of Funeral Service Licensee Vanne Held Lelle W	22. Name and Address of Facility	nardt Fu	neral C	hapel P.A
ysician	H	23a. Part I. Enter the disease, or complications that caused the death. Do	R296 Charmil Dr.	Manches espiratory arrest, sh	ster, MD	21102 Approximate Interval
nedical.		failure. List only one cause on each line.		,,	,	Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ardiovascular disease			
		Sequentially list conditions, b.				
	ine.	if any, leading to immediate Due to (or as a consequence of): cause. Enter underlying Gause				
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ne death certificate the attending phy ned for use as the	Physician/	past 12 months?	2 Fetal death 3 Ectopic pregnance 5 Other (Specify)	Э	Month Da	ay Year
death re atte for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
at the f by th tached		Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	ne cause of death?
res m signe be de	d by	Morbid obesity		1 Yes 2	No 3 Proba	ably 4 V Unknown
been hould	Completed			24a. Was an autopsy		opsy findings available
e law e has ge 2 s	E D			performed?	death?	
certificate ector, page		25. Was case referred to medical	26.Place of Death (Check on	1 Yes 2	No 1 🗸 Yes	2 No
is cer direct	Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ EF	TOthor:		dence 6 Other:	
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ath. he fur	흲	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
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ا تا جن سر ج		3 Suicide 6 Could not be determined (Specify)		or Town, State)		
urs aft rral Di	ertit		, death occurred at the time, date and place, and do	ue to the cause(s) a	and manner as state	d.
	al Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge,		he time, date and p	lace, and due to the	cause(s)
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		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23 Zabiullah Ali, M.D. Assistant Medical Examiner	29c. License number O.C.M.E. 3a) 111 Penn Street, Baltimore, MD 2120	29d Ap		th, Day,Year)
To the within 2 To the complete	Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23)	29c. License number O.C.M.E. 3a) 111 Penn Street, Baltimore, MD 2120	29d Ap		ith, Day,Year)

			For State		State of	f Marylar		artment of I			ental Hy	giene			
			Registrar 1. Decedent's Name	o /Eirot Middle Lo	n#1		Ce	rtificate of	Death		Reg. No.	2008	1 2	145	
	Physic			GIE DISNE	•						2. Date of De Month APRIL	Day	2008	3. Time 4:16	of Death
	/Medi Examii		4a. Facility Name (/			nber)		4b. City, Town, o	or Location		AFKIL		ounty of Death	4:10	A M
1	LXuiiii	×		LA MARIS		,		TIMONI					LTIMORE	,	
	Funeral		5. Social Security N	lumber 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Bir	rth	9. Birth	place (State	e or Foreign
- All	Director		212-34-6	1033	□M 21 F	100	Yrs.	Months Days	Hours	Min.	(Month, Da Dec 27	, 1907	1907 Country Mary1		
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	ocation					1.	10d Incide	City Limits
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	h with	Funeral Director	2300 Dul	laney Val	ley Road	d			21093		_		JSA	.,	
	deat ems ?	ner	11. Marital Status			dent Ever in U	.S. 13.	Was Decedent of I If Yes, specify Cub		igin? (Spec	cify Yes or No)- 14.	. Race - Americ		
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at			ied 2 ☐ Married	1 ☐ Yes If Yes, Giv	2 📉 No 'e		1 ☐ Yes 2 ☒ No			nican, etc.)		Black, White, pec <i>ify</i> : Wh i		
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b	be filed ntal Hygic of other event, tl	Bec	17. Father's Name	(First, Middle, Last)						er's Name	(First, Middle	, Maiden Su		ecy	
ylaı		2	William	Thomas P	feiffer				Ma	rgare	t Ann	Murk			
Maryland	and s m			ame/Relationship (1 sney/son	Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural	Route Numb	er, City or T	own, State, Zip	Code)	
	s 1 and 2 f Health item 27 I		20a. Method of Disp			20h 5		Hilltop	коаа						
altimore,			1 ☐ Burial 2 [☐Cremation 3 ☐			cemetery, crei	natory or other pla	ce)	Da	ate	20c. Locat	tion - City or To	own, State	
Itiu	C 60 3		21. Signature of Fu	5 Other (Specify	see//		22	2. Name and Addre	ess of Facili	tv.					
B	permit. Departi Importi any inj once.		R	onald S	Wade, D	irecto		tate Anat iltimore.			655 W.	Balt	imore S	Street	Ē
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1	/Medical		resulting in death)		Due to (or as a conseq	-	Cong	CZIIV	(11	(CA)	14110	1		
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<u>io</u>	endin ath. or: Af he fur	atio	1 Natural 2 Accident	5 Pending investigation	(IVIOITE	i, Day real)	injury		Yes 2 □	No					
Division or Vital	r Attrocer de irecte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place buildin	of injury - At ho	ome, farm, stre	eet, factory, office		28	If. Location (S City or Tox	Street and N	lumber or Rura	l Route Nu	mber,
Ω	oital o			-	1										
	To the Hospital or Attending Physician: within 24 hours after dealt. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	iner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the tile tile tile tile tile tile tile til	me, date an opinion, dea	id place, ar ith occurre	nd due to the d at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause	e(s)
	o the	Mec	29b. Signature, and	title of certifier	and mann	er stated.		29c. Licens	e number			29d. Date s	igned (Month,	Dav. Year)	
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7			30. Name and addre	11.01/10/	ompleted cause	of death (term	23a) (Type, I	Print)	-	,					9
_			ERNESTI.	NE WRIGHT				ANEY VALI	LEY RO	DAD	TIMO	VIUM	MD 210	093	
	Sta	-	31. Date filed (Mont		32. 86	gistrar's Signa	ture	- 100 -				_			
	Registr	ar	A	PR 2 5 20	UB Jak	gistiar's Sigria	1 190	WEL!							

4:16 A.M.

APRIL 14, 2008

DISNEY, NELLIE

		State of Maryland / Dep		Health and Me	ental Hygie	ene	3453			
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)			2. Date of Death Month	Day Year 4c. County of Dea	3. Time of Death			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 X F 1 M 2 X F 1 Usual Residence of Decedent	Randa1 y) If Under 1 Year Months Days	STOWN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan 19,	Baltime (Year) 9. Bir 1919 Ne	ore thplace <i>(Stat</i> e or Foreign ountry) W York			
C Z1Z15-UU36 filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be rediffed at	Director	10a. State			100	g. Citizen of What Co	10d. Inside City Limits ↑ Yes 2 No			
eath with is 23a or	Funeral Dir	2434 W. Belvedere Avenue		21215		USA 14. Race - Amo	•			
5-UU36 72 hours after d natural", or item	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	ican, etc.)	Black, Whit	e, etc.			
DESILIMOTE, INIGIT/JIANG 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Expressive must be notified at ance.	Completed	(Specify only highest grade completed) (Giver Secondary (0-12) College (1-4or 5+)	edent's Usual Occup re kind of work done DO NOT use retire	during most of working d)	7	Sb. Kind of Business enginee	•			
Maryland 2121 d 2 should be filed within in the and Mental Hygiene. 27 is marked other than "traumatic event, the the	To Be C	17. Father's Name (First, Middle, Last) Rudolph Diamant		18. Mother's Name (
Mary nd 2 shou alth and M 27 is mar	-			and Number or Rural Ta Drive Ba			. '			
DEBILLIMOTE, permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	oosition (Name of ematory or other pla	ce) Da	te 20	Oc. Location - City or	Town, State			
Dain permit. Depart Import any inj once.			22. Name and Addre tate Anat altimore.	ess of Facility Omy Board MD 21201	655 W. I	Baltimore	Street			
Examiner attending physician and tor use as the burial-transit	ical Examiner	23a. Palt 1. Enter the disease, or complications that caused the death. Do not e shotk, or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to final outcause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	the mode of dy	ng, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death			
. 0 00	Physician/Medio		☐ Ectopic pregnand ☐ Other (specify) _	гу		23d. Date of delivery Month Day Year				
neconds, F.O. he law requires that the de has been signed by the ge 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	ven in Part I.		o the cause of death?					
The lay ate has bage 2	e Completed	25. Was case referred to medical				prior to death?	utopsy findings available completion of cause of			
ding Physician: h. After this certific funeral director,	O B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Apatient 2 ☐ ER/Outpati	ent 3 DOA		e 5 ☐ Residend	ce 6 ☐ Other (Spe	ecify)			
DIVISION OF VICE To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, and the funeral director, the funeral director director, the funeral director directo	Certification: T	27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year) 28b. Time (Month, Day, Year) 28b. Time Injury 28b. Time Injury 28b. Time Injury 28c. Place of Injury - At home, farm, s	M 1 🗆	Yes 2 □ No	3d. Describe how	et and Number or R	ural Route Number,			
Hospital or 24 hours aft Funeral Distrely filled in	ledical Cer	4 Homicide building, etc. (Specity) City or Town, State) 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. All Homicide building, etc. (Specity) City or Town, State)								
To the within: To the comple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. Licens	se number (26)	290	d. Date signed (Mon.	th, Day, Year)			
Sta		30. Name and address of person who completed cause of death (Item 23a) (Type PCH VOA A TO THE STATE OF THE ST	y, Print) LST SL	ute 212	A Bal	Amre!	NO21211			
Registr		APR 2 5 2008 Januar & January	GINAL							

Division or Vital Records, P.O. Box 68760

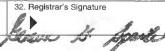
Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

ROINTAN FARAHIFAR

29b. Signature and title of certifier



M.D.

M.0

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ORIGINAL

29c. License number

D43446

29d. Date signed (Month, Day, Year)

4.22.08

9801 Georgia Ave suit 3-32 Silvers pring MD 20902

			For State of Mar State Registrar	ryland / Depa <i>Cer</i>	artment of Her <i>tificate of D</i>		ental Hygier Reg. I	2009	3 3460				
	Physici		1. Decedent's Name (First, Middle, Last) Ernest	Thomas I	Daniels,	Sr	2. Date of Death		3. Time of Death				
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical	Center	4b. City, Town, or t	Location of Death		4c. County of Death Baltimor					
*	Funeral Director		237-30-2392 ¥TM 2DE	(In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 5-31-19	9. Bin	rthplace (State or Foreign ountry) N . C .				
- 4	pug w		Usual Residence of Decedent	10c. City, Town or Loc	cation				10d. Inside City Limits				
	Manyla -f sho iled at	tor	MD N/A	Baltimo					1 √Yes 2 No				
	th the or 28a e notii	Director	10e. Street and Number	Daitimo	10f. Zip Code		10g. (Citizen of What C	21				
	s 23a o	ral	5708 Northwood Drive		21212			S A					
036	be filed within 72 hours after death with the Maryland Hydjene. Ind other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cuban I □ Yes ※□ No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: B					
2-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of worki	ng	Kind of Business	,				
21215-0036	d withir giene. r than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N		Clerk		Be	∍thleha	m Steel				
	0 = 0 %	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Surname)					
Maryland		2	James Carney 19a. Informant's Name/Relationship (Type. Print)	405 14-05-			Daniels						
_	ss 1 and 2 should of Health and Mer item 27 Is marke other traumatic		Rachael Daniels-Wife				Route Number, Cit e Balto						
altimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem				Location - City or	·				
	permit. Pages Department of Important: If its any injury or o once.		4 Donation 5 □ Other (Specify) 21. Signature of Funeral Price Licens		morial P		2008 Ran		own, MD				
ñ	Dep Imp		· Mars Must	7		1.07.00	177 - 27 CANDON CAR		MD 21202				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
) }	Physician /Medical		resulting in death)	ATIC CAN	CER OF F	ROSTATE	*		Onset and Death 1 YEAR				
	Examiner		Due to (or as a co		1 MONTH								
,	pe tis	iner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):									
	execute	Examiner		consequence of):									
8/e0	ficate be executed physician and s the burial-transit	dical E	d										
DO X	ertifica ling ph	Med	IF FEMALE:										
O. BOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within Planet Breater: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tin			23d. Date of delivery Month Day Year							
ν. Γ	ss that gned by e deta	by Ph	Part II. Other significant conditions contributing to death but r	not resulting in the un-	derlying cause given	in Part I.	23e. Did tobacco	o the cause of death?					
ecords,	require een sig oould b	ted		·	<u> </u>		1 Tyes	2 7 No 3□P	robably 4 Unknown				
2	The law te has boage 2 sh	Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of					
N II A	ctor, p	Be C	25. Was case referred to medical examiner?		- 2	26. Place of Death	1 Yes 2, 1 (Check only one)	No 1 ☐ Yes	s 2 No				
5	Physic this or	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient		4 LI Nursing Hon	ne 5 Residence		ocify)				
VISIOII OF	nding th. :: After e funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury a Work? M 1 ☐ Ye	es 2 □No	8d. Describe how in	ury occurred					
2	To the Hospital or Attending Physician: To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	o D Outside 6 D Could not be	- At home, farm, streed Specify)	et, factory, office	2	8f. Location (Street of City or Town, Sta	and Number or R.	ural Route Number,				
כ	pital cours af		29a. Certifier Charles a Certifying Physician: To the best of r	my knowledge deeth	accurred at the time	data and place.							
	n 24 ho n 24 ho ne Fun oletely	Medical	(Check only one) 2 Medical Examiner: On the basis of example and manner stated	(amination and/or inve	estigation, in my opi	nion, death occurre	ed at the time, date a	(s) and manner as and place, and dur	e to the cause(s)				
	Vithi To th	ž	29b. Signature and title of certifier		29c. License r	number	29d. D	Date signed (Mont					
		_	Mien-Dow Kion	/ _ D	D318	65		4/22/	10 f				
	8		30. Name and address of person who completed cause of deal MIEN-DOOR KIOUNE 7601	h (Item 23a) (Type, P DSLER DR)	,	SON. MA	RYLAND.	21204					
	Stat Registra		31 Date filed (Month Day Year) 32 Registrar's	Signature									
	og.out		Late to a many										

			For State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of L		Mental I	Hygiene Reg. No		10161	
	Dhuaici		1. Decedent's Name (First, Middle, Last)				2. Date o	f Death	2000	3. Time of Death	
	Physici /Medi		Scott Douglas	Edward			Apri	L 23,			
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		ath		. County of Deat		
-	Funeral		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hi	s. 8. Date o	F Rirth	Baltimo:	hplace (State or Foreign	
- 1	Director		213-70-3456 ^{¹X № 2□F}	51 Yrs.	Months Days	Hours Mi	1. Novem	Day, Year)	956 Mar	untry) Yland	
	pur »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	eation					10d. Inside City Limits	
	Maryla f shoved at	ō	Maryland Baltimore	Dundalk						1 □Yes 2 □XIo	
	the l	rect	10e. Street and Number	Durati	10f. Zip Code			10g. Cit	tizen of What Co	untry?	
	th with 23a o 1st be	al D	2027 Bear Ridge Road		212	22			USA		
р.ш. -0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2☐ X No	spanic Origin? n, Mexican, Pue Specify:	Specify Yes o	r No-	14. Race - Ame Black, White Specify: W		
1:45 p.m. 21215-0036	within 72 hd iene. r than "natul the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-12) College (1-4or 5-14)	(Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired; ntenance	ition uring most of w	orking	1	ind of Business/		
1 2 فر	e filed al Hyg other	ø	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Mic				
2008 arylar	2 should be filed and Mental Hygi Is marked other aumatic event, t	다	Clifford K. Edwards			Margar	et Ann	Dixon	n		
^ ≥	and 2 she ealth and n 27 Is m		19a. Informant's Name/Relationship (Type. Print) Debora Edwards Wife	2027	ng Address (Street a Bear Ridg		Dunda.	lk,Mar	yland	21222	
PRIL 23 altimore,	permit. Pages 1 and 2 should by Department of Heath and Menta Important; if Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Oak Lawn	matory or other place Cemetery	2	ril 26 008	, Dun	ocation - City or udalk,Ma:	ryland	
APRIL Baltim	permit. Departr Importa any Inju		21 Signature of Funeral Service Licensie On Thy My Complete		Name and Address onnelly F 110 Solle	rs Poln	t koad,	, Duna	alk,P.A alk,Md.	21222	
			23a. Part1. Enter the diverse, or complications that cause of shock, or heart facult. List only one cause on each line	the death. Do not ent	er the mode of dying	g, such as cardi	ac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical			EAL CANCER						Oliset and Death	
7	Examiner	ı	Due to (or as a								
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the property of the cause (Disease or injury that initiated events	consequence of):							
38760, 3	icate be executed physician and the burial-transit	dical Exa	resulting in death) Last C. Due to (or as a								
EDWARDS ds, P.O. Box 68	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome past 12 with 2 wi	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year	
[EDW rds, P	quires that n signed b ild be deta	by	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.				the cause of death?	
SCOTT EI	The cate h	Completed					- 8	Vas an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 ☐ No	
Z.	Physician: r this certificatal director, is	Be C	25. Was case referred to medical examiner? 1 Types 2 TW No. Hospital: 1 Types 1 Types 1 Types 1 Types 2 TW No.	nt 2∏ER/Outpatien	othe	26. Place of D			a V lau (a	HOCDICE	
ō	his ld	7: To	1 ☐ Yes 2 ☑ No 1 ☐ Inpatier 27. Manner of Death 28a. Date of Injury	y 28b. Time of	IL 3 DOA	4 LI Nursing		Residence ibe how inju		city) HOSPICE	
<u>ö</u>	ath. rr: After	atior	1 Natural 5 □ Pending (Month, Day 2 □ Accident investigation	Year) Injury		? ′es 2 □ No					
Division or Vital	al or Atte s after deg il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injurble building, etc.	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office		28f. Locati City of	on (Street ar Town, State	nd Number or Ru e)	ural Route Number,	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely illed in by the funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or in	h occurred at the tim vestigation, in my op	e, date and pla pinion, death o	ce, and due to curred at the t	the cause(s ime, date an	s) and manner as od place, and due	s stated. e to the cause(s)	
	To ti withi To ti	Ĭ	29b. Signature and title of certifier		29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)	
					NAS	125		4	1241	08	
	2		30. Name and address of person who completed cause of de								
	Sta	ate	DR. TARIO MAHMOOD 2300 DUI 31. Date filed (Mp/p) Day Yar) 2008 Registra	r's Signature	EY RD. T	IMONIUM	, MD 2	1093			
	Regist		WI WAS TOO								

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

with the Maryland

Maryland 21215-0036

Baltimore,

show

and A The law requires that the death certificate be executed burial-transit physician the has funeral director, this After t death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A the filled in by

completely 10 State

Medical

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

122 Speer Rd. Chestertown, MD.

Helen A. Noble, M.D.

31. Date filed (Month, Day, Year) APR 2 5 2008 Registrar



State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

21215-0036

Baltimore, Maryland

Box 68760,

P.O.

of Vital Records,

Division

32 Registrar's Signature

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	1	U	8-17	U	7

amend #30 Per Dvr G878 4/10/08 The of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** April 2008 Larry Featherstone 5:06 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Dec 27, 1947 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min 1**∑**M 2□F Months Davs Hours 60 578-60-1840 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4922 LaSalle Road 20782 USA Funeral unk 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un 15. Decedent's Education (Specify only highest grade completed) un 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk other other traumatic event, unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, Md 20912 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trai 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑ Other (Specify) in state 21. Signature of August Service Licensee Wade State Anatomy Board 655 W. Baltimore Street Director 23a. Partr. Enter the disease or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 **A**No 1 ☐ Yes Division of Vital 25. Was case refer Be 26. Place of Death (Check only one) examiner' Hospital: Other: 0 1 XInpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification; Injury or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funerel L the Hospital **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carrolle Ave. Ste 205 Takoma Park, MD 20912 Nasreen Mustafa Kango 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 4 2008

Registrar

			1 - For State Registrar	State	of Marylar		artment of F			lental H	lygiene Reg. No	711118	134	65
	Physici	30	1. Decedent's Name (First, Middle	(e, Last)	-					2. Date of I	Death Da	y Yeer	3. Time of D	eath
	/Medic		Dorothy Ross							April	18,	2008	12:45	P ^M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death			County of Dear		
			Gilchrist Ce 5. Social Security Number	nter @ GE 6. Sex	7. Age (In yrs.	last birthday)	Towson If Under 1 Year	If Under	24 Hrs.	8. Date of I	Birth	altimore	hplace (State or I	Foreign
	Funeral Director		192-16-6291	1 ☐ M 2 🗆 XF	85	• • •	Months Days	Hours	Min.	(Month,	Day, Year)	923 New	untry)	or orgin
1	ס		Usual Residence of Decedent							1 000	207 1	725 TIOW	_	
	anylan show dat	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City 1 ☐ Yes 2	
	Ba-f	ecto	Maryland Harf	ord	Be	l Air					1			. <u>A</u> .110
	with t	D I	10e. Street and Number	1			10f. Zip Code	4			10g. Ci	tizen of What Co	ountry?	
	eath	Funeral Directo	1 Glengate Co		cedent Ever in U	1.5 13	21014		igin? (Sn	ecify Yes or	No-	USA 14. Race - Ame	erican Indian.	
_	fter d r Itsn	Fun	1 ☐ Never Married 2 ☐ Mar	Armed i	orces? 2 3 No		Was Decedent of H			Rican, etc.)		Black, Whit		
2-003e	72 hours after death with the Maryland natural, or Itsms 23a or 28a-f show dical Examinat must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, C Year or	live Dates:		1⊡Yes 2∏xNo	Specify:	:			Specify: Wh	ite	
ဂ	n 72 hours after death with the Marylan "natural", or itsms 23a or 28a-f show circal Exeminer mant be notified at	Completed	15. Deceden (Specify only highe	nt's Education	()	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during mos	st of work	ing	16b. K	and of Business	Industry	
7	within ene. than "	ig m	Elementary/Secondary (0-12)	College	(1-4or 5+)									
2	77 00 -		17. Father's Name (First, Middle,	Last)		Veter	inary Ass	1		e (First, Midd		terinar	У	
	id be f ental i kad of	o Be	Ralph Hershey	*						y (nmn)				
2	2 should be and Mental Is marked raumatic ev	ပ	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street						Zip Code)	
Z	127 E		Leslie Faber /	Daughter	_	16 9	hannon Di	ciuc	B1	Air !	Vin 21	01/4		
e,	item item		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of matory or other pla	1		Date		ocation - City or	Town, State	
аппо	Pages nent of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	-	Service (4-23	3-08	Tow	son, Ma	ryland	
Salt	permit. Pages Depertment of the Important: If its any njury or of		21. Signature Funeral Service	Licensee		22	2. Name and Addre	ss of Facili	ity McC	Comas 1	Funer	al Home	. P.A.	
_	70 E # 9		23a. Part1 Enter the disease, or	1/2		1	317 Cokes	bury						9
			snock, or near failure. List	only one cause on	each line.	/	,	, '		or respiratory	y arrest,		Interval Betwee	een
<u>,</u> I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. INTESTING! OBSTRUCTION											
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. INTESTING OBSTRUCTION Due to (or as a consequence of):									MOOV.	<	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec		400						Month	
W	cuted	Examiner	that initiated events	S								Months		
Š,	sate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to	o (or as a consec	quence of):								
0/0/	certificate be executed inding physicien and use as the burial-transit	dicai		d										
o X O	res that the death certifics igned by the attending pt be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, o	utcome of orean	ancv						22d Date of de	li	
0	atten atten i for u	cian	in the past 12 months?									23d. Date of delivery Month Day Year		
j.	the d by the ached	hysi	9 Unknown	THE ZIMNO										
r.	requires that the death een signed by the atter hould be detached for u	by P	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause gr	ven in Part I	l.	23e. Di	id tobacco	use contribute to	the cause of dea	ath?
coras,	w require been sig should b										☐ Yes 2	∆ No 3□P	3 ☐ Probably 4 ☐ Unknown	
ပ္သ	A SE	pie								24a. W	as an itopsy	24b. Were a	utopsy findings av	vailable
	page 1	Completed								pe 1 ☐ Yes	rformed?	death?	2 □ No	
NI G	Attending Physician: The r death. •ctor: After this certificate he by the funeral director, page	Be	25. Was case referred to medica examiner?	Hospital:			1 0#			h (Check onl			- 11	
5		<u>2</u>	1 ☐ Yes 2 2 No 27. Manner of Death	11		28b. Time o				ome 5 Re 28d. Describ		6 Other (Spe	city) H3p	100
	After	ţ	1 Matural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	Injury	Wo	rk? Yes 2. □		200. 2000110	50 NOW 11170	ny cocamoa		
NISION	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Plan	ce of Injury - At h	iome, farm, sti	reet, factory, office		- 1	28f. Location	(Street a	nd Number or R	ural Route Numbe	er,
5	s afte	Certification:	4 Homicide	Duli	ding, etc. (Speci	<i>1y)</i>				City or Town, State)				
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the Examiner: On the	ne best of my kno	owledge, deat	h occurred at the til	me, date ar	nd place,	and due to the	he cause(s	and manner a	s stated.	
	the hin 2, the mplet	Medical	one)	and ma	nner stated.		29c. Licens							
	S I I I	-	29b. Signature and title of certifie	5)/1)) -		25C. Licens	701	-		A	ate signed (Mon	ay, real)	
	-0		30. Name and address of person	who completed as	use of death (Ital	m 23a) (Type	Print)	373		1	HPI	011 101	2008	
	1.7		DANIELE DOL	erman	M D	15/25	D64 N. Cha	rles	5	T. Su:	te 2	09 Ral	Impre M	1) 2120
	Sta	te	31. Date filed (Month, Day, Year)	008 632	Registrar's Sign	ature								5 4.20
	Registr	ar	APR 252	UUU JURGO	1									

			For State Registrar	State of M	larylan		rtment of H		nd Mental		ene	UU	108	, 00
	Decedent's Name (First, Middle, Last) 2. Date of Death											3. Time of	Death	
		Physician Helen P. Francesco Ap								1	2 ^{Day} 2	008	4:50	Р м
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of			4c. County	of Death		
H			Holy Cross Host	oital			Silver	Sprin	າຍ		Mont	gome	ry	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date	of Birth	(021)	9. Birth	place (State o	r Foreign
	Director		097-20-1759	□M 2X)F	79	Yrs.	Months Days	Hours	June	th, Day, Y 3 ,	1928		York	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10- 0:5	v. Town or Lo							104 114-01	
	ehov	_	Toa. State Tob. County										10d. Inside Ci 1 ☐ Yes	•
	Ba-f	Director	MD Montgo	omery	Ro	ckvil.								20110
	with t	풉	10e. Sireet and Number				10f. Zip Code			100	g. Citizen of \			
	• 23	sra	4711 Arbutus Av	7enue	A 17 1 1 b	S 140.1	2085		-0.40				tates	
	item item	Funeral	11. Marilal Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	S. 13. Y	Vas Decedent of Hi Yes, specify Cuba	n, Mexican,	Puerto Rican, et	c.)		ck, White		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or iteme 23a or 28a-f ehow event, the Madical Examinat must be notified at	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			☐ Yes 2☑ No	Specify:			Specify	Wh:	ite	
ş	2 hou	ted	15. Decedent's Ed				lent's Usual Occupa			16	6b. Kind of B	usiness/îr	ndustry	
212	hin 7	Completed	(Specify only highest gra	de completed) College (1-4or	.54)	(Give lite. L	kind of work done o OO NOT use retired	during most o)	of working	king				
7	d wit	ĕ	12	3030 (, 40.	.,	Loa	an Office	r			Bank	ing		
<u> </u>		Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, M	fiddle, Ma	aiden Surnan	ne)		
<u> </u>		2	William F. Sch	ıtzler				Emn	na M. Kr	uise				
a D	bue min		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number	or Rural Route N	Vumber, (City or Town,	State, Zi	o Code)	
	of Health of Hem 27 i		Lynn R. Bl	izzard /Da				Avenue		11e,	Mary1	and 3	20853	
<u> </u>	it of He		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State		lace of Dispo- emetery, cren	sition (Name of natory or other plac	e) A1	pril 28,		c. Location -	City or T	own, State	
Ě	Pages ment of ent: if it ury or o		4 Donation 5 Other (Specify				Memorial P	ark 📙	2008	R	ockvi1	le,	Maryla	nd
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service Licer	/ /)	101498	22 3	Name and Addres	, Inc.	Robert A	Pu St M	mphrey ontgom	Fun ery	eral H Avenue	ome/
			21. Signature of Funeral Service Licensee M01498 22. Name and Address of FacilityRobert A. Pumphrey Funeral Householder Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 23a. Parl 1. Enter the disease, or complications that caused the death. Shock or heart failure. List only one cause on each line.											е
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final											Death
	/Medical		disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of):										-	
	Examiner					,								
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	uence of):								
γ.	cuted	Examin	Cause (Disease or injury that initiated events	c										
Š	e exe		resulting in death) Last	Due to (or as	s a consequ	uence ol):								
8/60,	death certificate be executed e ettending physicien and nd for use as the burial-transit	dical	,	d										
٥	e as	Mec	IF FEMALE:											
X Q	death certific ettending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregnancy					te of deliv		Year
- -	that the de ned by the e detached f	/slc	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of de	eath 5	Other (specify)							
J.	hat the	4	Part II. Other significant conditions o	ontributing to death	but not resu	illing in the ur	deriving cause give	an in Part I	230	23e. Did tobacco use contribute to the caus				
cords,	8 50	d by	End Stage Renal			and an end of	idonying daddo give	31,111, 611,	255.				bably 4 🛣 L	
i လ	- 976	Completed	Coronary Artery				*		242	Was an	24h 1	Were autopsy findings available		
d)	e ia has	E C	Offinally infect	Discase						autopsy	ed?	prior to co death?	empletion of c	ause of
	icien: Th certificete rector, pag	e C	25. Was case referred to medical							Yes 20		1 🗌 Yes	2 No	
	Physicien: this certific ral director,	00	examiner? 1 Yes 2 No	Hospital:	inst 201	ER/Outpatien	Othe		of Death (Check			- 10		
Ö	Phy or this	2	27. Manner of Death	28a. Dale of Inj (Month, Da		28b. Time of	28c. Injury Work	4 🗆 (40)3	sing Home 5 28d. Desc		ce 6 ∐Oth		(y)	
DIVISION	nding th. :: Afte	atlon:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury		c? Yes 2∐No						
<u> </u>	Atte	=======================================	3 Suicide 6 Could not be determined	28e. Place of In	njury - At ho	me, farm, stre	eet, factory, office		28f. Loca	tion (Stre	et and Numb	er or Rur	al Route Num	ber,
5	rs afte ai Dir ed in	Certificati	4 - Hounda	bullaing, 8	tc. (Specify	,			City	or Town,	Jiaie)			
	To the Hospital or Attending Physically A hours after deeth. To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a. Certifier 1 ☆ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the besi niner: On the basis and manner s	of examinat	wledge, death tion and/or inv	occurred at the timestigation, in my or	ne, date and pinion, death	place, and due to occurred at the	o the cau time, date	se(s) and ma e and place,	anner as a	stated. to the cause(s	:)
	To th within To th	Me	29b. Signature and title of certifier	n n		1	29c. License	number		290	d. Date signe	d (Month	Dey, Year)	
) (!// ** **		all	12 11	1 D52	261			April	22.	2008	
	20	ł	30. Name and address of person who	completed cause of	death (Item	23a) (Type)						,		
	0		Alan R. Segal,	M.D. 151	7 Hugo	Circ	le Silver	Sprin	ng, Mary	1and	20906)		
	Sta		31. Date filed (Month, Day, Year)	32 Regist	traf's Signat	ture for	2489							
	Registr	ar	APR 2 5 20	UO MARCO	مار اساکا	18/10	Contract of the contract of th							

PATIENT RNOWN AS FORREST, SAIRLEY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Ir 4:54 A M APRIL 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 14 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 🗷 Months Days Hours 214-40-0061 6 land Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opeartment of Heath and Mental Hyghers. Instruction: If item 23 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examiliar mast burnation at Director 1 Kes 2 □ No nary lank IMOYE 10e. Street and Number 1 10f. Zip Code 10g. Citizen of What Country? 21215 United States oad Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐Yes 2 ZNo <u></u> Specify. 3 Widowed 4 Divorced Completed John Hopkins 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -aculity Club JOOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be thraham BrISCO Florence ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridgeview Manda -orrest-Daughter Batto 210 MD Road Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Baltimora, 4-29-08 Netro 4 ☐ Donation 5 ☐ Other (Specify) rematory 21. Signature of Funeral Service Licensee LIAMS alun L. V MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PULMONARY HYPERTENSION 2414 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 morths? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) P.0. 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ COP 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHF 24a. Was an Jas page 2 s autopsy perfor m certificate CHRONIC REML FAILURE 2 No 1 ☐ Yes 1 ☐ Yes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation Hospital or Attending 1 Natural death. 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 MA APRIL 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 SENGUPTA HOSP ITAL MD SINAL BALTIMORE SOMA 31. Date filed (Month, Day, Year)
APR 2 5 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 6 per fh 9878 4-25-08 vt.

State of Maryland 7 Department of Health and Mental Hygiene 1- State Registrar amend #20b&c Per FH G880 6/10/09 all of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 243 PM GEOIGE 200 S 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAITIMOLE

FUnder 1 Year | If Under 24 Hrs. HOSPITAI MEMOSIAI 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country)

MAYY | A IV D 6 Sex Social Security Number Funeral 4375 219 52 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show iner must be notlfied at 1 Yes 2 No BALTIMORE by Funeral Director 10e. Street and Number 10f, Zip Code 10g Citizen of What Country? 2/2 5 EAST 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIS ABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FE16USON 19a. Informant's Name/Relationship (Type. Print) AUA+ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAItO MA 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BAltimoRE 4 Donation 5 Dother (Specify) and Address of Facility Ph. 11 1A AU EATHERFORD PA FS 21. Signature of Funeral Service Licenses Phillip Aweathorized 2,431 Loi.ver 5+ BA

23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BA HE MA Immediate Cause (Final **Physician** disease or condition resulting in death) 10 Vasc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offe Physician/Medical Examiner HTW signed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058860 APRIL 23,2008

Calvert St. Svitesss BALTO, MD

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAWN DHILWN MD 3333 N.

32. Registrar's Signature

Acute

SHAWN DHILLON MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, **Physician** PLAMINI AEL 8008 Oril /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner 15a Cd. CH 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**√** M 2□ F Director 235-30-4583 84 <u>March20,1924Pennsylvania</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 TyYes 2 □ No Md. Baltimore **Funeral Director** City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 213 South Exeter U.S.A. Street 21202 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dundalk American Elementary/Secondary (0-12) College (1-4or 5+) Maintainance Legion 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael R. Flamini, Sr. Fortunata Quattrocchi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Flamini (wife) 213 South Exeter St. Baltimore, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4-28-2008 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGEST TUE NEAMI Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, and physician Physician/Medical signed by the attending of the detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy performed? (es 2 No certificate 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death . After t 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending Injury within 24 hours are:
To the Funeral Director: Aff 1 ☐ Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BONACUMMO301 PLacE 0111 31. Date filed (Month, Day, egistrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

2 5 2008

ENERAT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manual Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3.12A M APPIL Grembocki 2008 Stanley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEN BURNIE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 1914) 6. Sex 1 M 2 ☐ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Director March 24, 1916 New York 069-10-2561 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 212 Southwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ☐Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pepsi Bottling Company Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Kempkoska Anthony Grembocki Gladys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Southwood Road Pasadena, Maryland 21122 Patricia H. Tribett (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/16/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) INEUMOTHORAX /Medical Due to (or as a consequence of) Examiner MENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner us to (or as a consequence of) burial-transit MEMIA Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician for use as the buria PERTENSION Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? /es 2 No 1□ Yes 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnie NABAID Hospital Drive
p2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Margaret V. Goller 2008 12 April 6:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Edenwald Retirement Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🕅 F 89 Director 215-40-6074 Aug 1, 1918 Austria Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show Director event, the Medical Exercitive count by notified MD 1 ☐ Yes 2 ☐ No Baltimore Towson 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or filed within 72 hours after death with 800 Southerly Road 21286 **IISA** Funeral Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married P Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 2 3 Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jakob Kurzbock Cacilia Plursch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Treffner/son HC 36 Box 229 Tallsmanville, WV 26237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 23a. Part 1. Inter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** 11 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ page 2 should be 1 □ Yes 3 Probably 4 Unknown Completed has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification funeral director, p Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 2 100 Certification: To 1 Tes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 Tyes 24 hours after death. Funeral Director: A investigation 2 □ No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check onl one) within 2 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) inpriessing breme Year) 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	FOI	ertificate of Death	Reg.	2000	13412	
	Physici /Medio		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month OH	Day Year 2008	3. Time of Death 8:25 A M	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death Anne Arur	dol	
-			Baltimore Washington Medical Cente: 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Glen Burnie Glen Burnie If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtho		
	Funeral Director		249-46-9507 1□ M 2 F 88 Yrs Usual Residence of Decedent	Months Days Hours Min	June 28, 19	19 Coun	place (State or Foreign stry)	
	he Maryland 8a-f show otified at	ctor	10a. State 10b. County Baltimore 10c. City, Town or	Glen Burnie		10d. Inside City L 1 ∰Yes 2		
	th with th 23a or 28 Jet be no	al Director	10e. Street and Number 305 Columbus Road	10f. Zip Code 21060	10g.	Citizen of What Cour	ntry?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sin If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 250 No Specify:		14. Race - Americ Black, White, Specify: Bla	etc. ck	
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d 2	filed Hygir other ent, th		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Surname)		
ılan	should be f and Mental b s marked of umatic eve	To Be	Frank McKenzie	Josephine Le	wis			
, Maryland	1 and 2 sho Health and I tem 27 is ma	ľ	19a. Informant's Name/Relationship (Type. Print) Catherine Henderson / Daughter 19b. M 305	ural Route Number, Ci urnie, Maryla	ute Number, City or Town, State, Zip Code) e, Maryland 21060			
Baltimore,	Pages 1 and of He		Burial 2 Cremation 3 Removal from State	sposition (Name of strematory or other place) vary Cemetery 04/2	Date 20c 26/2008 Will	Location - City or To		
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee		Wylie Funera	1 Home, P.A.		
	10		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one dause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between	
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	/Medical Examiner		Due to (or as a consequence of):					
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68760,	tificate be executed ig physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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Δ.	ires that signed by	و ک	Part II. Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.		co use contribute to the	ne cause of death?	
Records,	w require been si should t	letec	Abremors Demant 9	,	24a. Was an		psy findings available	
al Re		Completed			autopsy performed 1 Yes 2	prior to co	mpletion of cause of	
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other:	ath (Check only one)			
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Division	afor Atter after deaf I Director d in by the	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)	
	/		1 and crear	D4681		4/2		
	5		30. Name and address of person who completed cause of death (Item 23a) (Tyl	S RICETET,	10079	GLEN E	SEANIE 14	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Phistrar's Signature	head !			ew t	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Vear **Physician** GROSS LIESEL APRIL 2008 7:10A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 04/07/1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours GERMANY 88 218-01-7280 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County 28a-f show 1 □Yes 2 No Director traumatic event, the Madical Exertainer is ust be notified OWINGS MILLS MD BALTIMORE the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours after death with 23a 21117 4730 ATRIUM COURT, #362 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 □Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GARMENT **SEAMSTRESS** is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be HAAS LOUIS GOLDSCHMITT FRIEDA ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 2525 CARROLLTON ROAD, PATAPSCO, RICHARD GROSS / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Pages 1 1 X Burial 2 ☐ Cremation CHEVRA AHAVAS CHESED 04/24/2008 RANDALLSTOWN, MD 4 Dogation /5 Other (Specify) SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** M67957471 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of law requires that the death certificate be executed V S resulting in death) Last Due to (or as a consequence of) burial P.O. Box 68760, physician Physician/Medical the . 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 **A**No page this certificate 1 □ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ASSISTED Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely 2 Medical 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 8008 2048 of death (Item 23a) (Type, Print) 30. Name and address of person who completed of 6 (ASJON Month, Day, Year) 31. Date filed 32. Registrar's Signature State 'Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Margarita Huertas 4 0800 AM 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUORE HOSPITAL CENTER Rosedal Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Year) November 20, 1913 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 F Hours 069-12-9282 Director Puerto Rico Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Dundalk Director Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 2007 Barry Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: Puerto Rican 21215-0036 1ăyes 2□No Specify: Puerto Rican ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital 2 vears Nurse 12 years other 1 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Diega Ruiz Alfonso Santiago 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau 2007 Barry Road, Dundalk, Maryland 21222 America Rodriguez Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 25, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2008 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. winoul 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. It only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxaemia Du to (or as a consequence of): days /Medical **Examiner** obstruction Airway ob
Die to (or as a robsequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Acute Colonary physician ar s the burial-to Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MalnuTriTion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Kyphoscoliosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) myas 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

State Registrar DR MYA S. Thein
31. Date filed (Month, Day, Year)

APR 25 2008

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 2.3 per dr., 88/9,05/14/08dhb

Amend Item I per dr., 88/8,04/24/08dhb

Legarin end of Health and Mental Hygiene

Amend Item I per dr., 88/8,04/24/08dhb

Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04/09/2008
Month Day Mathilde **Holmes** OD P M **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AResulle Fairhaven 7200 Third 9. Birthplace (State or Foreign Age (In vrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day) 5. Social Security Number 6. Sex **Funeral** Year) Days Mary Land 1 □ M 2 🗗 F Months Hours 216-46-1865 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or rother traunatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 → No Director Sykesville MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue C128 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gaylord Lee Clark Juliana Keyser ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Avenue C128 Sykesville, MD Rutherford Holmes/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee Agde, Director State Anatomy Board 655 W. Baltimore Street Baltimore. MD 21201

23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** intarction ninutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cardiomy opathy plars. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performe certificate 252 No Division or Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director. the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of April 9 2008 D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. III am Tan MD 1645 Lib (Road Eldersburg MD 21784 12 Liberty . Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 4 2008 State (Buch Registrar

			1- For Amend Item 24a per dr., 2878, 0	partment of Health a 1/24/08dhb Certificate of Death	nd Mental Hy	giene Reg. No. 2008	13475
	Physicia		Decedent's Name (First, Middle, Last) REBA HE	YMAN	2. Date of De Month APRIL	Day Year	3. Time of Death 2:20A M
of the same of	/Medic Examin		4a. Facility Name (If not institution, give street and number) 800 WILLIAM STREET	4b. City, Town, or Location of BALTIMORE		4c. County of Death	
	Funeral Director		5. Social Security Number 215-09-9481 6. Sex 1 M 2 X F 7. Age (In yrs. last birtho	Months Days Hours	8. Date of Bin (Month, Do 04/17/	ay, Year) Cou	place (State or Foreign ntry) ND
	aryland show	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o				10d. Inside City Limits
	he M	Director	MD N/A BA	LTIMORE 10f. Zip Code		10g. Citizen of What Cou	
	23a or	ral Dir	800 WILLIAM STREET	21230		USA	
9036	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene and other than "natural", or items 23a or 28a-f show event, I're Medical Exeminar must be retified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowldowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican,1 ☐ Yes 2 No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify: WH	etc.
Maryland 21215-0036	within 72 h ene. than "natu o Medical	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of fe. DO NOT use retired) COUNTANT	of working	16b. Kind of Business/Ir	,
9	Hygie Hygie ther		17, Father's Name (First, Middle, Last)		s Name (First, Middle	ACCOUN] , Maiden Surname)	ING
lan.	d d d	To Be	MAX AUSLANDER		BESSIE		CKER
lary	2 should to and Menical Menica			ailing Address (Street and Number		per, City or Town, State, Zi	p Code)
	D = C +			127 E. MONTGOMER	Y ST., BA	LTIMORE, MD 20c. Location - City or T	21230
	Pages nent o ant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANSE CHAPTER ANS COMPLETE CHAPTER AND COMPLETE CHAPTER CH	sposition (Name of crematory or other place)	4/13/2008	BALTIMORE	
Bal	permit. Departi Imports any infi		21. Sign ture of Funeral Service ticensee	22. Name and Address of Facility 8900 REISTERST		NSON & BROS.	
	hysician /Medical	1	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as c			Approximate Interval Between Onset and Death
	Examiner	L	Due to (or as a consequence of): Sequentially list conditions b.	my uptay			4-
	ansit	edical Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events	Tanon			
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Box	e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	very Day Year
rds, P.	requires triat the leen signed by the hould be detached	۾	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		tobacco use contribute to Yes 2 ☐ No 3 ☐ Pro	
- Rec	ate has	Completed			24a. Was auto perfo	psy prior to co ormed? death?	opsy findings available ompletion of cause of
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ō	this ald	입	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at		idence 6 Other (Spec how injury occurred	ify)
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DIVISION	s after de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (City or To	Street and Number or Rui wn, State)	al Route Number,
tice of o	or the rospital of Attenuing within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, companies of examination and/or and manner stated.	eath occurred at the time, date and or investigation, in my opinion, death	place, and due to the n occurred at the time,	e cause(s) and manner as date and place, and due	stated. to the cause(s)
ķ	withir To th	Me	29b. Signature and title of certifier	29c. License number	201	29d. Date signed (Month	
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	12			pe, Print) UDSON STREET, BA	LTIMORE, M	D 21224	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 4 2008				

		1 - State Registrar	of Maryland / D	epartment of F <i>Certificate of I</i>		-	giene Reg. No. 200	3 13477		
Discosia:		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death		
Physicia Medio/			rine Huband	I		April	23°, 20°			
Examin	er	4a. Facility Name (If not institution, give street and 15220 Emory Lane	'number)		r Location of Death cville	1	4c. County of De			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		irthplace (State or Foreign Country)		
Director		528-50-7242 1□ M 2X	F 93 Y	rs. Months Days	Hours Will.	August 1	5, 1914 U	tah		
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
a-fsh	ctor	Maryland Montgomery	Roo	kville			1 □Yes			
or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Country?		
eath w Is 23a	Funeral	15220 Emory Lane	Decedent Ever in U.S.		0853	pecify Ves or No.	United S	States nerican Indian,		
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hyglene. Other than "natural", or items 23a or 28a-f show ent, it is Medical Examinar must be notified at	by Fun	1 Never Married 2 Married 1 Yes,	Forces? es 2 XINo	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2∑No	Specify:	o Rican, etc.)	Black, Wr			
2 hou satural		15. Decedent's Education	16a. I	Decedent's Usual Occup	pation	delman	16b. Kind of Busines	s/Industry		
ithin 7 ne. han "r	Completed		e (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of wor d)	Kirig	O II	_		
filed w Hygie ther ti		12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Nan	ne (First, Middle,	Own Home Maiden Surname)			
ild be fental rked o	To Be	Joseph Peterson				y Peters				
2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print)	1	Mailing Address (Street			•			
T, E	3	Patricia Huband/ Daugh 20a. Method of Disposition				kville,	Maryland 2			
ages ant of litt: If ite		1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	om State	Disposition (Name of crematory or other place) Ogden Cemet	, 11211	.1 29,	North Ogde			
perfilliole, Infally faller Z1Z13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Medical Examination in Cilias I alone.		21. Signature of Funeral Service Licensee	_		ss of Facility mphrey Fun	eral Home	/Bethesda-Che	evy Chase, Inc.		
		23a, Part 1. Buter the disease, or complications th	M01305 at caused the death. Do no	<u> </u>				Approximate Interval Between		
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sician: The law scertificate has t lirector, page 2 s	Completed					autor perfo	psy prior t ormed? death	autopsy findings available o completion of cause of ? es 2 □ No		
ysician: The is certificate h	Be C	25. Was case referred to medical examiner?				1 ∐Yes ath <i>(Check only c</i>		es 2 INC		
Physic this or	၉	1 ☐ Yes 2 🛣 No Hospital:	☐ Inpatient 2 ☐ ER/Out		4 🗆 Nursing F		dence 6 ☐ Other (S	pecify)		
ding Ph	tion	27. Manner of Death 1 M Natural 5 ☐ Pending 2 ☐ Accident investigation		jury Wor	ryat k? Yes 2 □ No	280. Describe I	how injury occurred			
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funderal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification:	3 Suicide 6 Could not be	l lace of Injury - At home, fare uilding, etc. <i>(Specify)</i>	m, street, factory, office		28f. Location (: City or To	Street and Number or wn, State)	Rural Route Number,		
Hospita 24 hours Funeral etely filler	Medical C	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and n								
To the within To the Comple	Me	29b. Signature and title of certifier	00	29c, Licens	se number		29d. Date signed (Mo	nth, Day, Year)		
		Maria The	telmach,	MD D253	346		April 23,	2008		
4		30. Name and address of person who completed of			C4 +-	#200 B	- 1	[a-v-1] a-1 200E0		
Sta	te	Marcia Goldmark, M.D. 31. Date filed (Month, Day, Year) 33.	15020 Shady Registrar's Signature		, suite	#300, KO	ockville, M	laryland 20850		
* Registr		APR 2.5.2008	Dance & B	dearle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Hawkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Year 1810 hrs Medical Examiner JAMES HAWKINS April 23, 2008 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 1308 North Caroline Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 214 04 If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) **Funeral** Foreign Country) MD Months Days Hours 0469 Director DEC.8,1941 \mathbf{x}^{M} 2 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a, State 10b. County 1X Yes 2 No BALTIMORE N/A 28a-f show MD rector hours after death with the Maryland 10g. Citizen of What Country? s 23a or 28a-f e notified at o 10f. Zip Code 10e. Street and Number 21213 USA ō CAROLINE ST. 1308 N. 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Yes BLACK Specify: 3 Widowed 4 Divorced If Yes, Give Yee 1 Yes 2X No specify: permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 CENTRAL BOOKING CIVIL ENGINEER 10TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CATHERINE YOUNG THOMAS HAWKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANCES Y. HAWKINS 1225 N. SPRING ST. BALTO, MD. 21213 (wife) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State apr.30,2008 BALTO,MD. ARBUTUS MEM.PK. Ponation 5 Other Specify: nature of Funeral Service Licensee 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part I. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Hypertensive Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 5 per fh g879 5-2-08 vt UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a I be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 ✔ Probably 4 Unknown Diabetes Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed' Yes 2 ✔ No To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: After this certifit completely filled in by the funeral director, I 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other, Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , M. D April 24, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Mook), Ray 4ea 2000

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verbal, 878,04.25,08dbb reg. No. 25 per verbal, 88,04.25,08dbb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** homas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign County) **Funeral** 10 M 2 F Days Hours -62-5436 Yrs Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehov The Medical Examinar must be notified at 1 Des 2 No Marylan Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [DNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubag, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) a Compan is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name_(First, Middle, Maiden Sumame) Be 2 should be f and Mental h Thomas Joan Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Queen - nother Maryland Health ttem 27 Battimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date Department of H Important: If its any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses uneral Home P.A. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Meta disease or condition resulting in death) menthe /Medical Due to (or as a consequence of): Examiner wherewi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, þ 4 Unknown Completed 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 ☐ Yes 2 No 1 Yes 2 Mo or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only e) Hospital: 1 🗌 Yes Other: ို 4 ☐ Nursing Home → sidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 27. Mann of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Fo the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month

cause of death (Item 23a) (Type, Print) DAN IEC

BALTIMORE

. Registrar's Signature

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l.	Dhysia	ion.	Decedent's Name (First, Middle, Last)						2. Date of Month		ay Year	3. Time of Death		
À	Physici /Medi		Robert James Janne						April	2	0 2008	0650 AM		
	Examir	ner	4a. Facility Name (If not institution, give s	treet and number)		4b. City.	Town, or	Location of De	ath	4	c. County of Deat	h		
	× .	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. E. Months Days Hours Min. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Months Days Hours Min. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months Days Man. (A. M. O. O. C. 7.) 128 M 2 D F. Months								Date of Birth 9. Birthplace (State or Fore				
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	with th		10e. Street and Number 329 Westowne Road			10f. Zip					Citizen of What Co	untry?		
	ss 23,	eral		2. Was Decedent Ever in U.	C 12		.228	coania Origin?	(Consitu Vac or		SA 14. Race - Ame	rican Indian		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show spir julyry or other traumatic event, the Medical Evanting must be notified at ance.	by Funeral	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☑ Yes 2 ☐ No		if Yes, spe		n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	140-	Black, White	e, etc.		
Maryland 21215-0036	hour furel	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates: 1963-	16a. Dece	dont's Hey	al Occupa	ation		16h	Kind of Business/	Industry		
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<u>lar</u>	should be and Mental I s marked o	To E	Fred Janney					Jennie	Jachim	ski				
an	2 sho and I is ma		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address	(Street a	and Number or	Rural Route Nur	nber, City	or Town, State, 2	Zip Code)		
	s 1 and 2 of Health a item 27 is other trav		Carol Janney	Wife	10000			Road;			Marylar			
ore	ges 1 r of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Dispo emetery, crea	nsition (Nai matory or c	me of other place		Date	20c.	Location - City or	Town, State		
Baltimore,	tmen tant: tant:		4 ☐ Donation 5 ☐ Other (Specify)	Met	ro Cr		-		4/2008			, Maryland		
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-	40200		23a. Part1. Enter the disease, or complic	Mo149	0	L630_	Edmo:	ndson A	venue:	Cator	sville,	MD 21228 Approximate		
	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consequ	rdice of):	2/	In	fore	hor)		Interval Between Onset and Death		
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sio	Attending Physicien: r death. sctor, After this certification the funeral director, in	cati	2 Accident investigation			М		res 2 □ No						
Division of Vital Records,	9 4 2 5	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factor	y, office			(Street a Fown, Sta		iral Route Number,		
	To the Hospital or Attending Physicien: Within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 12 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my know er: On the basis of examinati and manner stated.	wledge, death ion and/or in	n occurred vestigation	at the tim	e, date and pla pinion, death oc	ice, and due to the curred at the time	ne cause e, date a	(s) and manner as nd place, and due	stated. to the cause(s)		
	To the To the Comp	M	29b. Signature and title of certifier	B		290	c. License	number		29d. D	ate signed (Monti	h, Day, Year)		
)			& aigine	Mull	2	The state of the s	Do	0631	28	1	oril à	0,2008		
	nx\		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print)				, ,		10-0		
	4,		Sargine Brutus	St Agr	nes Ho	spita	1	Balti	imore ,M	d 21	215			
	Sta Registr	_	APR 2 5 2008	32. Registrar's Signat	ure Gos	Les of								

*30 Janney, Robert &

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

Funeral

Director

filed within 72 hours after deeth with the Maryland

Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached:

Division of Vital Records, P.O. Box 68760,

	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 📉 Donation 5 ☐ Other (Specify)	amoval from State	cemetery, crematory of	other place)						
	21. Signature of Funda Signature Rona Ld S. W	ade Mrector		and Address of Facility Anatomy Boar nore, MD 212		ltimore	Street			
	23a. Part1. Enter the disease, or complice shock, of heart failure. List only on Immediate Cause (Final	ations that caused the deat e cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death			
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xaminer	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a conseq								
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic			23d. Date of de Month	delivery Day Year			
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De	25. Was case referred to medical examiner?				ath (Check only one)					
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ertitio	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or R te)	lural Route Number,			
edical Certification	29a. Certifier (Check only one) 12 Certifying Physical Cartifying	s) and manner a nd place, and du	s stated. e to the cause(s)							
2	29b. Signature and title of certifier	Wilnich 1	m	9c. License number) 1929	y Ap	ate signed (Mon	th, Day, Year)			
	30. Name an odress of person who cor	melnich	911 Rus	sell Are.	Gaithers	my Mi	1. 20879			
	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature 🥒			U'				

State Registrar

JOHN 31. Date fled (Month, Day, Year)

APR 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 ear April **Physician** 8:47 рм Kenneth Moody Jones /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Nov. 25, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Illinois Min. Months Days Hours 1 M 2 □ F 88 Ĩ919 332-24-3422 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Evantment by notified at once. Md. Baltimore Timonium 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 12261 Roundwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Moody Charles Jones ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Jones/ Son 297 Summit Drive Ijamsville, Md. 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-28-08 Timonium, Md. Dulaney Valley Mem. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by LSTructer lun disease 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the P within 24 To the F 29b. Signature and title of certifier 29c. License number Bolto, Md 2,2008 up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Rila

31. Date filed (Month, Day, Year)

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A.

W.

DHMH 17 Rev 1/2001

ORIGINAL

N. Charles

		, roi	partment of Health and Mental ertificate of Death	Hygiene	13483
Phys	ician	Decedent's Name (First, Middle, Last) Bronislawa Ja	2. Date Aremczuk Apri	of Death th 17, 2008	3. Time of Death 9:38 P.M
	dical niner		4b. City, Town, or Location of Death Baltimore	4c. County of Dear	
Funer Directo		5. Social Security Number $212-56-4739$ 6. Sex $1 \square$ M $2 \cancel{\Xi}$ F 7. Age (In yrs. last birthda Yrs.	Months Days Hours Min. (Mon	nth, Day, Year) Co	thplace (State or Foreign outry) land
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icate be executed physician and strength	ical Evaminar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Cuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Cortification.	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		ation (Street and Number or F or Town, State)	Bural Route Number,
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í		1 /600 3	D 33448	April 18,	2008
6		30. Name and address of person who completed cause of death (Item 23a) (Type Kenneth H. Williams, M.D. 280	l Foster Ave. Baltin	more, Md. 2	1224
	State istra	31. Date filed (Month, Day, Year) APR 2 5 2008 Registrar's Signature	berle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 98/8 4-25-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death ent's Name (First Middle Year **Physician** 1:254 M 2008 Apri /Medical (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Kandallstown Bastimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex (In yrs. last birthday) Funeral Months Days Min 1 ☐ M 2 NF 3 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Ses 2 No MD Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or name, Injury or other traumatic event, the Market and Once. 1825 21227 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) Elementary/Se College (1-4or 5+) abore ommerc Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type State, Zip Code) -imore, md alaat 1825 Center ousi a Marleen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore, 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stago disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to or as a conse wence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HIV 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hepatits 24a Was an 2 No 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 112 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 Mysilian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Kelstorstown MD LOVCE MAN Smeet 31. Date filed (Month, Day, Year) Registrar's Signature 32 State APR 25 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 4-212-2008 12:45PM Marie A. Kraus 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balto. Manor Care- Rossville Balto.Co. If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Months Min Hours 1 □ M 2 □ XF 86 215-12-4416A 1-25-1922 MdUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md. 1 ☐ Yes 2√☐ No Balto. Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13209 Cherwin Avenue 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Vittek Mary B. Peterka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. DiMattei DTR. 13209 Cherwin Avenue Middle River, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Holy Redeemer 4-25,2008 Balto.Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Steppe tno disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

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27. Manner of Death T Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
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	nysician: To the best of my kniner: On the basis of examin				and manner as stated. place, and due to the cause(s)				

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Signature a

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03.56 AM GRACE KINLEIN APRIL 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HARBOR HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 10/11/1922 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Months 1 □ M 2 🕱 F 85 218 18 5968 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 👿 No be notified Director Maryland Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 305 Walton Avenue 21225 U.S.A. 23a death v Funeral the Medical Examiner must 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White <u>م</u> 3 Nidowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator University of MD. Hosp marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hiant: If item 27 is marked oth Be Earnest Leroy Hoxter Emma Margaret Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
important: If Item 27 is
any injury or other trau Sue Sturms / Daughter 305 Walton Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Pemoval from State 04/21/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Sign thre of Frineral Service Licens 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 DAYS Physician SEVERE SEPSIS /Medical Due to (or as a consequence of): Examiner UNKNOWN PNEUMONIA Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1☐ Yes 2 🛣 No Month Year Day 4 □ Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, DIABETES MELITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ADVANCED DEMENTIA 24a, Was an page 2 s autopsy perform certificate HYPERTENSION 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Nnpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier RES000 APRIL 18 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADEKUNLE OBISESAN, HARBOR HOSPITAL 3001 SOUTH HANDVER STREET, BALTIMORE, MARYLAND 21225 31. Date filed (Month, Day, Year) 326 Registrar's Signature State Registrar APR 2 5 2008

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** 18, Gloria Dawn Konski April 1:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 332 Bracken Lane Swanton Garrett 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 84 Director 217 14 0780 11/04/1923 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1X Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3442 Second Street 21225 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: δ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Own Home permit. Pages 1 and 2 should be filed v
Depenment of Health and Mental Hygies Important: If Item 27 is marked other tt
any injury or other traumatic event, this once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Webster Captiola Burdett ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Konski / son 332 Bracken Drive Swanton, Maryland 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 04/22/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 ponths?
1 Yes 2 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} \boxtimes$ Other (Specify) ${}_{5} \square$ ${}_{7} \square$ ${}_{8} \square$ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 2 No : After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funeral Director:, completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1K Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23979 4/18/08 ss of person who completed cause of death (Item 23a) (Type, Print) Robert Goralski, MD 411 N. Fourth St., Oakland, Maryland 31. Date filed (Month, Day, Year) 🟂. Registrar's Signature State APR 2 5 2008 Registrar

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State of Maryland / Department of Health and Mental Hygiene

ugene Rodger Ka	1- For State Certificate of Death
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Medical Examine	Eugene Rodger Kay, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Rousby Hall Road and Chestnut Drive Lusby Calvert
Funeral Director	5. Social Security Number 489 66 0945 6. Sex 1
any	Usual Residence of Decedent 10a. State
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rith the 5.23a o notifi	12629 Holly Circle 20657 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	
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5-00 led with tygience other the Me	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
121(d be fill fental be arked swent, d	UNKNOWN Kathy L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AD 21 2 should 1 and Me 27 is ma matic ev	Tammy L. Kay (Wife) 5110 Wetzel Ave, Cleveland, Ohio 44109
re, N I and F Healtl Fitem	20a. Method of Disposition 1
Pages Pages nent of lant: I	Naperville Cemetery April 26,2008 Naperville. III.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygienc. Important: If item 27 is marked other than "r injury or other traumattic event, the Medical E	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical .xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): b.
	Sequentially list conditions,
60, are be executed hysician and e burial - transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
be exec	UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit edical Certification: To Be Completed by Physician/Medical Exhalical Certification:	
the dea	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O. res that signed b	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires freate has been signage 2 should be	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The last certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)
of Viting Physical Physical Control of Viting Ph	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Vother: Scene
on o ending ath. or: Aft the func	1 Natural 5 Pending Apr 19, 2008 arr) 0049 hrs 1 Yes 2 No Driver of motorcycle fixed object collision
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. Ineral Director: After this certificate has been signed by fitted in by the funeral director, page 2 should be detach Certification: To Be Completed by P	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide Homicide Could not be 4 Homicide Could not be 4 Homicide Could not be 4 Homicide Could not be Coul
Division of To the Hospital or Attending Physiph 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Medical Certification:	
Z S F S E	
	Mousine Mill O.C.M.E. April 19, 2008
10+1	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	APR (. 3) / (DID) //Gradian . //s //Appendix/
Registra	Tit it is a man I had been been a land on the land of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 33 se-38 terndale the . Age (In yrs. last birthday, Date of Birth (Month, Dak, 9. Birthplace (State or Foreign **Funeral** 0 Days 1 ☐ M 2 🗗 F Months Hours Min Director ennessee Usual Residence of Decedent death with the Maryland 10a. State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Black, White, etc American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify. ⋧ Specify 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (144or 5+) marlow Be (17. Father's Name (First, Middle, Last) 18 nord ပ 19a. Informant's Name/Relations ip (Type. Print) Daushier 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. st rden No 0 Bunn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c Location - city or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility VO\$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed Exami burial-trans and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 💆 No Month Year Day 5 Other (specify) P.0. the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 🕅 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy certificate perforr Division of Vital 2 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ? 2 No Hospital: Other: 4 Nursing Home 5 Residence 1∐ Yes 2 ER/Outpatient 3 DOA this Certification: To 1 Inpatient 6 Other (Specify) funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hin 24 hours after death. the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 9 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day Year)

APR 2 5 2008

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40th

Registrar's Signature

			For State Registrar	State of Ma	ryland /		rtment of F tificate of		d Mental Hy	giene Reg. No.?	008	13490
	Physici		1. Decedent's Name (First, Middle, La Henrietta H. Love	ist)					2. Date of De Month April 1	eath Day	Year	3. Time of Death
**	/Medio		4a. Facility Name (If not institution, gi	e street and number)		-	4b. City, Town, o	r Location of De		-	ounty of Death	1100
	Funeral Director			Gex 7. Ag <i>e</i>	(In yrs. last t	birthday) _ Yrs.	Lothian If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, Da	th	nne Arund 9. Birthp Cour	place (State or Foreign
	and		Usual Residence of Decedent 10a, State 10b. County		10c. City, To	wn or Loca	ation			, ,,,,,,	11	0d. Inside City Limits
	Maryl	tor	MD Anne Aruno	lo l								1 □ Yes 2√√ No
	or 28	Director	10e. Street and Number	le I	Lothi	<u> </u>	10f. Zip Code			10g. Citize	n of What Coun	ntry?
	s 23a		6340 Mallard Lane	10.111 5		1		711			USA	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exarinar must be multified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 Tho If Yes, Give XX Year or Dates:			as Decedent of H Yes, specify Cuba □Yes 2 □ No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		. Race - Americ Black, White, e pecify:	
5-0	72 ho "natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	(Give ki	ent's Usual Occup	during most of w	rorkina	16b. Kind	of Business/Inc	
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>0 NOT us</i> e retired lanage r	1)	9		Banking	
nd	al Hyg I other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	Maiden Su		
Maryland	should be and Menta s marked umatic ev	70 10	Carman Hawkins						vearengin			
Mai	nd 2 sho Ith and 27 is ma r traums		19a. Informant's Name/Relationship (Erin Love	Type. Print) Daughter	19				<i>Rural Route Numb</i> an, MD 207		own, State, Zip	Code)
ore,	es 1 and 2 of Health a item 27 is r other trau		20a. Method of Disposition		20b. Place		tion (Name of atory or other place		Date Date		tion - City or To	wn, State
Baltimore,	. Page Iment Iment Iant: If		1 ∑ Surial 2 ☐ Cremation 3 ∑ 4 ☐ Donation 5 ☐ Other (Special	y)	1		h Cemetery	:	22, 2008	Cookev	ille, TN	
Bai	permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once.	0	21. Signature Lanneral Service Licer Gregory vink 23a. Part1. Enter the disease, or com	7 Francis	T48	12.17		Hwy S.,	Glen Burni		21061	
11	Chicate be executed with the provided as the burial-transit as the	cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) South fally list could be failed and failed	a. Due to (or as a c. Due to (or as a	a nsequence	failure Fibro	acate	diopa	hic	1	Interval Between Onset and Death Say	
	the death cer by the attendir ached for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒☒No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	☐ Fetal deat		Ectopic pregnancy Other (specify)	/		230	d. Date of delive Month	ery Day Year
Records, F	w requires that s been signed is should be deta	β	Part II. Other significant conditions of	ontributing to death but	not resulting	in the und	erlying cause give	en in Part I.		obacco use ∕es 2∑X		ne cause of death?
		Completed										psy findings available mpletion of cause of
Vital	ysıcıa is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	2 ER/0	Outnationt	3 DOA Othe		eath (Check only o		701- 10 11	
ion of	or en Pospiral or Attonding Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	\vdash	27. Manner of Death 1	28a. Date of Injury (Month, Day,	28b.	Time of Injury	28c. Injury Work		Home 5 Resid			<u>'</u>
Division	Ital or Att Irs after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	(Specify)				City or Tou	n, State)		l Route Number,
	n 24 hou	edical	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination a	ge, death o ind/or inve	occurred at the time stigation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) an date and pla	nd manner as st ace, and due to	tated. the cause(s)
į	Vithi To th	M	29b. Signature and title of tertifier	777			29c. License	number)	29d. Date si	igned (Month, L	Jay, Year)
	6	-	30 Name and address of meson who	ME.	4b (1b 2		10	3/11		HAV	il 29	t, 2008
	7)		30. Name and address of person who	completed cause of dea) 3	O 5	Hospin	of D	sive, G	Jen B	you)	W-21061
	Stat Registra	_	APR 2 5 200		Janature	Gosa						

Registrar

			For State	State	of Maryla		artment of F rtificate of			lental Hy	_	7 11110	13491
K.		4	Registrar 1. Decedent's Name (First, Mic	idle. Last)			- Inicale of	Deali		2. Date of D	Reg. No. 3 T		3. Time of Death
	Physici		PAUL SAUNDERS							Month APRIL		oay Year 1 2008	7:00 P M
	/Medic Examir		4a. Facility Name (If not institut				4b. City, Town, o	r Location	of Death	THILL		lc. County of Dea	
-			FOREST HILL HE.	ALTH & RE	HABILITA	ATION	FOREST	HILL			I	HARFORD	
	Funeral		5. Social Security Number	6. Sex 1 🔀 M 2 🗆 I		s. last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of B	irth ay, Yea	9. Bir	thplace (State or Foreign
	Director		216-24-8432 Usual Residence of Decedent	I LALIVI ZUI	80	Yrs.					15,		nnsylvania
	land ow		10a. State 10b. Coun	nty	10c. 0	City, Town or Lo	ocation					<u>.</u>	10d. Inside City Limits
	Mary -f she lied a	ţō	 Marvland Harfo	ord	D.	el Air							1 ☐ Yes 2 📆 No
	r 28a	Funeral Director	10e. Street and Number	ora	Do	2T WIT	10f. Zip Code				10g. C	Citizen of What C	ountry?
	th with	al D	306 I Canterl	bury Road			21014				US	SA	
	ems er mu	ıner	11. Marital Status	12. Was D	Decedent Ever in I Forces?	U.S. 13.	Was Decedent of H	lispanic O	rigin? (Sp	ecify Yes or N	0-	14. Race - Am Black, Whi	
36	s afte , or it	by Fu	1 Never Married 2 M M	arried 1 🖸 Ye	es 2 ☐ No Give		1 ☐ Yes 2 ☐ No	Specify		,		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d b	3 Widowed 4 Divorce	ent's Education	or Dates:	160 Door	dent's Usual Occur	ation			1 Ch		White
5	in 72 in 72 in a	Completed	(Specify only high	hest grade complete		(Give	kind of work done DO NOT use retire	durina mo	st of work	ing	160.	Kind of Business	rindustry
212	with yiene.	mo	Elementary/Secondary (0-12	Colleg	e (1-4or 5+)	_	sman & Ma		_		Tr	surance	Company
	e filed al Hyg other	Be C	17. Father's Name (First, Middle	le, Last)			MIRCHI O IA			First, Middle			company
<u>lar</u>	uld by Menta Irked Itic ev	To E	Paul Saunder:	s Lake Sr	•			Marg	garet	Cathe	rine	e Hess	
Maryland	2 sho and I is ma auma		19a. Informant's Name/Relatio	nship (Type. Print)		19b. Maili	ng Address (Street	and Numb	per or Rur	al Route Num	ber, City	or Town, State,	Zip Code)
	and and n 27		Barbara H. Lal	ke / Wife			[Canterb				ir,	Marylan	d 21014
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 □ Cremation	n 3 □Removal fro	om State	. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	-	Date	20c.	Location - City or	Town, State
Baltimore,			4 □ Donation 5 □ Other	(Specify)	I		s Luther			-08	Kir	ngsville	, Maryland
Bal	permit Depar Impor any ir		21. Signature of Funeral Service	ce Licensee		,	Accomas F			•			_
	20200		1317 Cokesbury Road, Abingdon, Maryland 2										
			shock, or heart failure. L	3a. Part / Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	Physician /Medical		disease or condition resulting in death)	a. 1		are d	Courtes						
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8760,	cate be executed oblysician and the burial-transit	dical		d									
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ta			25. Was case referred to medic	cal				26 Plac	o of Doot	1 Yes ∩ (Check only		No 1 ☐ Ye	s 2⊠ No
Ž	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hoopitals	☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	or \				6 □Other (Spe	acity)
יסר			27. Manner of Death	28a. Da	ate of Injury Month, Day Year)	28b. Time o	f 28c. Injui Wor			28d. Describe			.ony)
Division	endir ath. or: Af he fur	Certification:	Z LJ / lociderit	stigation	onin, bay rour,	injury		Yes 2 □]No				
ž	after death. Director: A	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete		ace of injury - At uilding, etc. (Spec	home, farm, str cify)	eet, factory, office			28f. Location City or To	(Street a	and Number or R	ural Route Number,
Ω	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		_										
	Hospita 4 hours Funeral tely fille	ical	29a. Certifier 1 N Certify (Check only 2 Medic	ying Physician: To al Examiner: On th	ie basis of examii	nowledge, deat nation and/or in	h occurred at the ti- vestigation, in my o	me, date a pinion, de	nd place, ath occur	and due to the red at the time	e cause , date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29b. Signature and title of certi	and m	nanner stated.		29c. Licens						
	₹ <u>₹</u> 8		David 3	7					est -			ate signed (Mon	
	11			on who completed :	auga of dooth /IL	om 22a) (T		22	17		p	w 22,	2001
	15+1		DR. DAVID DUN			, , , ,	AD - BEL	ATD	MD 0	1017			
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e of Maryland / Department of Health and Me	ntal Hygiene 🛭 🗎 🥛	13	49	2
Certificate of Death	Reg No.			

			Juliu J. Maria J.	Certificate of L	Death	Reg.	No.		
	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month	Dey	3. Tir	ne of Death
	Physicia /Medic		VIRGINIA L. MULLINS		0.5	APRIL 3	14 D	008 10	35 PM
	Examin	er	4e Fecility Neme (If not institution, give street and number)		4b. City, Town, or Loc HANOVE		4c. County	of Death	NAI
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest bi	rthday) If Under 1 Year					
	Funeral Director	ctor	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1 Norths 1						RLINIS
e, maryiand 2121	how		10a. State 10b. County 10c. City, Tow	n or Location		-			de City Limits
	89-f.s			OUER					Yes 2 No
	ath with the Merylen 23a or 28a-f show	Funeral Director	7301 OHIO AVENUE	10f. Zip Code	76		US		
	72 hours after death with the Merylend natural, or items 23s or 28s-f show dital Experiment has the Hilled at	þ	11. Maritel Status 1 □ Never Merried 2 □ Married 3 ■ Wildowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ▼ No It Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba		cify Yes or No- tican, etc.)		e - American India k, White, etc.	_
	72 ho	eted	15. Decedent's Education 16a (Specify only highest grede completed)	Decedent's Usual Occupa	ation during most of workin	g 16b	. Kind of Bu	siness/Industry	
	within ene.	To Be Completed	Elementary/Spcondery (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired			NI	Δ	
	Hygle Hygle ther ti		17. Father's Neme (First, Middle, Last)	H0031_00	18. Mother's Name	(First, Middle, Maid	ten Sumem	e)	
	d be i		FRANKLIN YOUNG			RUCH	_	,	
	shou ind M imari umati			. Mailing Address (Street	and Number or Rure	Route Number, Ci	ty or Town,	Stete, Zip Code)	
	and 2 paith a 127 is		Critical Partic	A DINO 106		ure , mi	7 31	076	
	Pages 1 nant of He nt: If Item			f Disposition (Neme of ry, crematory or other place	ce)	The second secon		City or Town, Sta	
	F # 3		4 □ Donetion 5 □ Other (Specify) AR by	ent couma		-25-08 H	(ANOI	אושצ, די	.0
ğ	permit. Depertr Importu		21. Signature Juneral Service Licensee	22. Name and Address		LEY DRIVE	N. H	stroug	MOSION
	100		23a. Part1. Enter in disorde, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Appro	ximate al Between
	Physician		Immediate Course /Finel					Onset	and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. Zm Ch Sluce						
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W	axecuted in and ial-transit	Examiner	Sequentially list conditions.	consequence of).					
Š	ficeta be axecuted physicien and is the burial-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.						
09/90	certificeta be nding physicie use es the bur	edicai		consequence of):					
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į.	Physician: The law requires that tha death ce this certificate has been signed by the attendi rel director, pege 2 should be datached for use	Physician/	Part II. Other significent conditions contributing to death but not resulting in	n the underlying cause give	eninrani.	1 Yes	2 No	3 Probably	
or vital Rec	requires thet tha teen signed by th hould be datache	۵							
	equire sen si ould	Completed				24a. Was an a performed	utopsy I?	24b. Were auto available	opsy findings prior to in of cause
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	cate h	ပ်				1 □ Y65	27 No	1 ☐ Yes	2 No
	ician certifi recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	strationt all DOA Oth	26. Place of Death		0 000	(0/4-)	
	r this erel di	⊢⊩	27. Menner of Deeth 28e. Dete of Injury 28b.	Time of 28c. Injury	4 Li Nuising non	ne 5 Residence 8d. Describe how i			
VISION	Attending Physician: r deeth. ector: After this certific by the funerel director,	Certification:	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No arm, street, factory, office 28f. Lo					
<u> </u>	r Atte	율	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, for building, etc. (Specify)				Location (Street and Number or Rural Route Number, City or Town, State)		
5	urs after or real Direction	Cer							
	How 24 ho Fur staly f	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2						use(s)
	To the Morpital or Attending Physician: The Is within 24 hours after deeth. To the Fuerral Director: After this certificate ha complataly filled in by the funeral director, pege	Me	29b. Signature and itile of certifier	29c. License	e number	29d.	Date signed	(Month, Dey, Y	ear)
	->-0		1 de la como	D41	1907		4.2	80.2	
	6	-	30. Neme end address of person who completed cause of deeth (Item 23e)	(Type, Print)	1/0	\ 0		11	1.1
			John Mars - Hard	2408 MO	untern K	2 ras	ryen	MAY MAY	md
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrer's Signeture					,	

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ethic 3:55 PM 1PRIL /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WSON BALTIMORE ARC NANOR If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Ye 04 - 05 -5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday **Funeral** Months Days Min Year 1 M 2 DF OPTO-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd Mental Hygiene. marked other than "natural" or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at 1 ☐ Yes 2 DNo Director timorc altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 DNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 SSISTANT Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, in once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ amue 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29556 Hemingway (Name of or other place) 1046 ortia Daje 20b. Place of Disposition (Name of cemetery, crematory or other place) . Method of Disposition J20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify 195 (Thurspood Marshall Blud 21. Signature of Funeral Service Vice 22 Name and Address of acility Henryhand typeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA SECUNDARY TO TRAUMATIC **Physician** BRAIN INJURY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CER 2 → NO 3 □ Probably 4 □ Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy pertormed? death? 1 □ Yes 1∐ Yes 2 100 2□No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 W Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

CEUNAUS RICHADSUN 31. Date filed (Month, Day, Year)

29b. Signature and title of contifier

29a. Certifier

(Check only one)

Medical



· P .

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1257722

29d, Date signed (Month, Dav. Year)

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PILESVILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Aprill 10:35^Pм Robert H. Moyer 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/06/1927 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F 212-24-9529 Maryland 80 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, It a Medical Examiner must be notified at MD. Baltimore Director Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9018 Chateaugay Court 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: WW 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 □Yes 2 X No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Defense Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos Walter Moyer Phoebe Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Moyer / Wife 9018 Chateaugay Ct. Baltimore, MD. 21234 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Moreland Memorial 04/25/08 Parkville, MD. 20a. Method of Disposition Department of Important: If ite any injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Tuneral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 art 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNA 42ARS /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). ned by the attending physician and attached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform of Vital 1 ☐ Yes 1 ☐ Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 22,2008 064395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, 8417E209 BALTIMOTE MU 21204 DOBERMAN MO DANIEUE 32 Registrar's Signature 31. Date filed (ModPRY, 2°35 2008 State

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Registrar

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Robert

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEMFICE DEFEL (879, 5/8 / 8 WS)
State of Maryland 7 Department of Health and Mental Hygiene (1) (1) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month -**Physician** 2008 3:05A 001 Karen Jean Marten /Medical Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner - harlestown Himore timore Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 □ M 2 🛛 F Yrs 089-30-2995 69 March 15,1939 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number **709 Maiden Choice Lane** 306 Ingleside Avenue Ap 10f. Zip Code USA 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Herus Margaret Freel Johansen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STephanie Boisvert 1001 Arunah Avenue; Catonsville, MD 21228 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 4/25/2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of Funeral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician mentio years disease or condition resulting in death) /Medical (or as a consequence of): Examiner Hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy signed by the atte in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Yes 2 | 1 | Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Hatural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Certification: After To the Hospital or Attending within 24 hours after death. 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maide Ston

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MOORE 2:50AM EONAR 2008 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 ALTI SECOURS 105 MORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F 239-60-4103 75 Director July 18, 1932 North Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD 1∏Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2009 Longwood Street 21216 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) maintenance apt bldgs 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rethella Franklin/friend 1700 E. 28th Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5 NOther (Specify) in state State and Address Faces oard 655 W. Baltimore Street 21. Signature Funera Spice dicentre de , Director 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician JHELL MONIA /Medical Due to (or as a consequence of): CARDIOVASCULAR DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner MELLITUS DIABETES and burial-trar resulting in death) Last Due to (or as a consequence of) signed by the attending physician dbe detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of Injury

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this certificate has been After ours after death.

neral Director; A
filled in by the fi

funeral within 24 hours a

Certification: To

Medical

Sta	te
Registr	ar

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

(Month, Day

29c. License number D0030355

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Tyes

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

BON SECOURS

28d. Describe how injury occurred

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Month 04 **Physician** 2008 Moore Jr. 6:10a. M W. Charles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville 600 C East Gude Drive Year) 54 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months 1 ▼M 2 □ F 54 Director 212-64-2718 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Mardeal Evan in action with distance. 1 ☐ Yes 2X No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20814 7728 Woodmont Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No Specify: Specify: S Q Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Freight Loader 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane Rollins ပ္ Charles Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 2613 Oswego Ave, Baltimore, Md Perris Moore-Brother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/08 Baltimore, Carmel 22. Name and Address of Facility
March F/H West ve of ∯uneral Service License Signa 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed es feu h'on 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Norsing Home 6 Other (Specify) recovery 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To house After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

29a. Certifier

(Check only

29b. Signature and title of certifier

onstanti

31. Date filed (Month, Day, Year) APR 2 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Khlydever.

32 Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

M.D.

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

		•	For Amend Items	State of Mar 17,23a,Pt	yland / Dep	artment of I	Health and N 78,04/24/	lental Hygi 08dhb	ene g. No 2 0 0 8	13499	
	Dhysisi	an.	1. Decedent's Name (First, Middle, Last				•	2. Date of Death	Day O Yea	3. Time of Death	
4.4	Physici /Medic	cal ner	Tina	Mar	go		llister	Hpril	5 200	8 1:04 PM	
	Examin		4a. Facility Name (If not institution, give street and number) ST Agnes Hospital			Baltimore			4c. County of De	4c. County of Death	
	Funeral Director		214-00-3740	JM 2MTE	(In yrs. last birthday,	Months Days		8. Date of Birth (Month, Day, 05 23	Year)	irthplace (State or Foreign Country) MD	
	72 hours after death with the Maryland natural; or items 23a or 28a-1 ehow disal Exemples must be nollfied at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits	
		ţ	MD NA		Balt	imore				1 XYes 2 □ No	
		Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What		
		ra D	3722 Nortonia	Road		2.	1216		U.S.		
36		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ௴vivorced	12. Was Decedent Ev Armed Forces? 1 Yes No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	nerican Indian, hite, etc. B lack	
5-0036	n 72 hours natural',						16b. Kind of Business/Industry				
21218	- 6	Completed	Elementary/Secondary (0-12)	dary (0-12) College (1-4or 5+)		ve kind of work done during most of working a. DO NOT use retired)			N		
121	be filed within 72 ho stal Hygiene. rd other then "natur event, the Madical		12th grade	na	Nu	rsing A			Nursing	Home	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental Hygiene.	Be	James L. McCalls	ter Sr.	-			e (First, Middle, M Matthe			
Ž	s 1 and 2 should f Health and Men item 27 ie marke other treumatic	ဥ	19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mail	ing Address (Stree	t and Number or Rui	al Route Number,	City or Town, State	, Zip Code)	
	5 € Z = Z		Delores McAllia		er 372	2 Norto	nia Road	, Balti	mre, Md	21216	
Je,	of Health item 27 i		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla		Date 2	0c. Location - City	or Town, State	
Ē	Page nent o int: If iry or		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		-	-		2/08 R	andalls	town, Md	
Baltimore,	permit. Pages. Department of h important: if ite any injury or of		21. Signaturi o Funeral Service Licens	> 12 K	ek 4	2. Name and Addr 366h Wab	ess of Facility H West asn Ave,	Baltin	ore, Md		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	e, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line.					st,	Approximate Interval Between Onset and Death	
			Immediate Cause (Finat Onset an Onset an							unkn	
100		er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):							4	
		n n	cause. Enter Underlying Cause (Disease or injury								
o Î	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
8760	ate be hysicia the bu	Ical		d							
9	artifica ing ph a as ti	Med	IF FEMALE:								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2\overline{\text{No}}\text{ of the past 12 months?} \\ 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg 4 Pregnant at time of death 5 Other (spec) 9 Unknown Unknown Other (spec) 1 Vest Ves							23d. Date of delivery Month Day Year	
		by	b.	Part II. Other significant conditions of Diabetes	ntributing to death but	not resulting in the	underlying cause g	iven in Part I.			to the cause of death? Probably 4 Dynknown
of Vital Records,		Completed	Aspiration Pneumonia					24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?		
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			1-		th Check only one)		
of	Hospital or Attanding Phys 4 hours after death. Funeral Director: After this tely filled in by the funeral dir	P.	Tes 2 ANO	Hospital: 1 Inpatient		III SLI DOA			nce 6 Other (S	pecify)	
		lo li	27. Manner of Death 1 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (Wo	ork? ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred		
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, si (Specify)			28f. Location (Str. City or Town,		Rural Route Number,	
		edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
. 1	within 2 To the		29b. Signature and little of certifier		.10	29c. Licen	ise number	29	d. Date signed (Mo	onth, Day, Year)	
	(0)		- Whi	113/	MO	レ	WØ53	512	april	5,000	
	(2)	1	30. Name and address of person who call the Heng	omplets was of dea	ath (Item 23a) (Type	caton o	avenue	, Balti	more, A	10 21228	
10		State Registrar 31. Date filed (steenth Day, Many 8 Registrar Signature Signature)									

McAllister, Tina

ORA

P.O. Box 68760. Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician APRIL : 10 A M Lora Ruth Mora ,200X /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F 49 220 70 0045 03/01/1959 Director Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Marvland Anne Arundel Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be ready. 7944 Fort Smallwood Road 21226 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Doran ျှ Joyce Quesenberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Mora / Daughter 7944 Ft. Smallwood Road Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04/23/2008 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD Physician EXACERBATION /Medical Due to (or as a consequence of): Examiner METTE FAILURE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transil Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death as been signed by the a 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 1□ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ D**O**A P 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Injury 1 Anatural 5 Pending To the moor after death.

Vithin 24 hours after death.

To the Funeral Director. Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 10053703 APILL 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

Registrar

DIMONE

WASNINGTON

MODICAL

GLEN BURNIE MD